An investigation of response to different treatment modalities in Cognitive Behavioural Therapy for Obsessive Compulsive Disorder

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Award date:
2020

Awarding institution:
University of Bath

An investigation of response to different treatment modalities in Cognitive Behavioural Therapy for Obsessive Compulsive Disorder

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A thesis submitted for the degree of Doctor of Philosophy

University of Bath

Department of Psychology

September 2019

Abstract

Background: Obsessive Compulsive Disorder **(**OCD) is a relatively common mental health problem that is known to be particularly disabling. Cognitive Behavioural Therapy (CBT), which inevitably includes Exposure and Response Prevention (ERP)[1] is effective and is the first line (and only evidence-based) psychological treatment for OCD. However, a large proportion of service users do not respond optimally to CBT in both the short and long term. The National Institute for Health and Care Excellence (NICE) recommends that an intensive version of treatment be made available to those who have not responded to two or more courses of CBT. Research on the reasons for such treatment failure has predominantly been investigated from the perspective of clinical services and the rationale for recommending intensive treatment is weak. Little is known about service users or therapists' views on reasons for treatment failure and the recommended alternative therapy formats in CBT, or on how widely intensive treatment is utilised, or even the current state of the evidence-base for this format. The aim of the current thesis is to gain a deeper understanding of each of these areas.

Method: A wide variety of methods are used to gain a rounded understanding. Study 1 comprised a systematic review to assess the current evidence for the use of intensive CBT for OCD.

Study 2 utilised a mixed methods design to investigate the experience of treatment failure from the perspective of the service user. Participants with OCD (n = 6) and Panic Disorder (n = 6) who had previously experienced $\geq$ 2 unsuccessful courses of CBT were recruited.

Study 3 utilised qualitative methodology to explore participants' views on the experience of or prospect of undertaking CBT in an intensive format. Participants with OCD (N = 30) who had previously experienced $\geq$ 2 unsuccessful courses of CBT took part.

Study 4 employed mixed methods to investigate psychological therapists' (N = 132) attitudes towards delivering intensive CBT and their utilisation of this format in their clinical practice.

Study 5 utilised a quantitative approach to investigate participants with OCD (N = 235) preference for treatment format from both a practical and therapeutic perspective.

[1] Cognitive Therapy (CT) (including elements of exposure) and Exposure and Response Prevention (ERP) (a form of behaviour therapy) do not differ significantly in clinical outcome (Öst et al., 2015). Thus, for the purposes of this thesis they will be referred to synonymously as CBT.

Study 6 utilised qualitative methodology to explore the experience of relapse from the perspective of the service user. Participants with OCD (N = 27) had previously experienced $\geq$ 2 unsuccessful courses of CBT, followed by a successful course of CBT after which they experienced a relapse in their OCD.

Results: Study 1 identified four Randomised Controlled Trials (RCTs) providing evidence of promise for efficacy of this format. However, further high quality RCTs are required for a meta-analysis from which more definitive conclusions can be drawn. Study 2 revealed that participants mainly attributed therapy failure to the therapeutic interaction. Most reasons identified were pertinent to both participants with OCD and PD suggesting that such factors are specific to CBT rather than OCD. In Study 3 intensive CBT was perceived by participants as acceptable and facilitated aspects of CBT that a weekly format was unable to. Participants also reported reservations about the intensity of the format. In Study 4 therapists perceived intensive CBT to be equally or more effective than standard CBT, although barriers to its use in clinical practice were identified. Study 5 revealed that participants with greater functional impairment and an experience of CBT failure or intensive CBT showed a greater preference for an intensive format. In Study 6 a combination of life stressors, cognitive and behavioural patterns and a lack of follow-up after CBT were identified as contributors to relapse.

Conclusions: The results of this research provide support from patients and therapists for the NICE recommendation of an intensive version of CBT for those whom treatment in a weekly format has been unsuccessful. However, it is unlikely to be widely available and there may be scope for hybridisation. Further research is required to address the provision of follow-up after the completion of CBT. The clinical implications of the findings are discussed along with study limitations. Further directions for future research are proposed.

Frequently cited abbreviations

American Psychiatric Association	APA
Clinical Global Impression-Improvement scale	CGI-I
Clinical Global Impression- Severity scale	CGI-S
Cognitive Behavioural Therapy	CBT
Diagnostic and Statistical Manual for Mental Disorders	DSM
Exposure and Response Prevention	ERP
Improving Access to Psychological Therapies Programme	IAPT
Intensive Cognitive Behavioural Therapy	iCBT
International Classification of Diseases	ICD
National Health Service	NHS
Obsessive Compulsive Disorder	OCD
Panic Disorder	PD
Post-Traumatic Stress Disorder	PTSD
Randomised Controlled Trial	RCT
Selective Serotonin Reuptake Inhibitor	SSRI
Structured Clinical Interview for DSM	SCID
The National Institute for Health and Care Excellence	NICE
Yale-Brown Obsessive-Compulsive Scale	Y-BOCS

Acknowledgements

Life is what happens…. in my case, whilst you are writing a PhD. Although, not all that happens in life is conducive to writing a PhD. The course of my PhD, I would say, has taken the 'off road'/ scenic route, with a few more bumps, road blocks and U-turns than anticipated. However, there have also been some beautiful vistas, and I would like to thank those who have stood by me and provided support, help and encouragement throughout this process.

My supervisory team Professor Paul Salkovskis, Professor Sarah Halligan and Dr James Gregory. Paul, when I first met you in 2007 at the WCBCT in Barcelona and you suggested the idea of coming to the UK to undertake a PhD, I did not realise quite the journey it would be. And wow! What a journey it has been! Thank you for your belief in me and for your ongoing support (even if I do have to sit outside your office door to get it!). I'm very grateful to you for all the fantastic opportunities over the past years. I have learnt so much and having the opportunity to work clinically with you certainly transformed my clinical practice and was definitely the icing on the cake that was worth moving continents for.

Sarah, thank you for taking on the supervision of my PhD. Your input has been invaluable, and I have learnt so much for you. You are an inspiring mentor, thank you for your help and patience. James, thank you for your support and particularly for the fantastic clinical discussions, it has been brilliant to be able to discuss the clinically meaningful implications of my research with you.

I want to thank the fantastic OCD charities and the brilliant people who run them; Ashley and the team at *OCD UK*, Olivia, Phillip and Collette at *OCD Action* and Dianna and Maria at *Maternal OCD*. This research would not have been possible without your support, encouragement and help, it has been invaluable. Thank you so much.

Thank you to all the participants in the studies. Thank you for your interest, time and openness, I have enjoyed talking with you and hearing your stories so much.

The Graduate school for funding my tuition fees.

Chris Edwards who was the most excellent placement supervisor during my clinical training in 2003. Chris inspired me to work with people who are experiencing OCD and showed me how. He then became my first boss and mentor and encouraged me to undertake this PhD. Thank you, Chris, for your belief in me and your continued encouragement over the years.

Lesley Anderson, you were one of the first people I met on arriving in the UK, and you have become a best and very special friend. Thank you for your amazing support with my PhD, your tremendous help with formatting and editing! You are a queen.

Elaine Gallagher, I don't think I would have made it through this without your friendship and support. You have helped me in more ways than I can explain in words-thank you will never be enough. Now let's make some candles!

Filipa Alves-Costa, thank you for being there 'here and now' even when I was not on the same continent. I am so grateful for your friendship, help and support.

Karlijn Vandenbroek thank you for your ongoing support, friendship and belief in me and for reminding me to not take this all so seriously and to occasionally have some fun! And for your brilliant feedback.

A huge thank you to Claire Forrest and my colleagues/ friends who have helped with editing and proof reading; Richard Hamshaw, Rosie Mcguire, Andreas Bauer, Sophie-Anne Purnell, Pamela Jacobson and Gemma Taylor.

The fabulous PhD office crew of 3.02; Andreas Bauer for the shared countless weekends in the office, your support and reminders to take a break! David Walter for your always kind and helpful chats and keeping me updated on what's happening in the world that does exist beyond 10 West Psychology. Lukas Litzellachner for your tremendous stats knowledge, perpetual enthusiasm and helpful advice. Rosie Mcguire for your incredible kindness, understanding, help and 'old soul' support. Craig Gunn for your wise chats and support and Niall Mcloughlin also, despite you MIA-ness.

My PhD brother and sisters; Brynjar Halldórsson for being a great colleague and friend and the second qualitative reviewer of Study 2. Fiona Challacombe and Karen Robinson, both for your pragmatic advice, empathy and kind encouragement.

The PhD journey has been enriched by all the fantastic people I've met along the way who have become friends. I could write another thesis to name all of you and to describe how each of you have contributed to my journey and have been a special part. We are such an international bunch and I haven't forgotten you, despite my lack of contact, I will be coming to visit soon! For now, a special mention and thank you to Meike Scheller, Kelly Clifford, Carol Clifford, Jo Black, Steve Dean, Ayumi Teshima, James Doodson, Niamh Ni Shuilleabhain, Bhagy Patil, Hannah Heath, Alaa Al Khourdajie, Chiara Scarampi, Keely Gunson, Anna Ferguson, Angie Dallimore, Anne Cottle, Carly Green, Hayley Johns and Vip Patel.

My Australian crew of besties who have been cheering me on from across the oceans; Joy Hamilton, Sharon Marsh, Allie Ackland Prpic, Semone Money, Tina Allington, Keryn Washington, Kasia Bartkowski, Alex Taylor-Engelaar, Karina Winen, Erika Sullivan, Alicia Mancuso, Anthony Radosevic, Leticia Aust, Amber Rowndtree, Nadia Del Col and a special thank you to Dianna Miller.

Professor David Veale, Dr Blake Stobie, Margaret Dakin, Julie Twomey, the previous directors and team at CADAT for your interest, support and help.

Professor Greg Maio thank you for your ongoing support, for being such a terrific head of department. Somehow you seem to have more hours in the day than everyone else, I hope to one day find out your secret!

Dr Catherine Hamilton-Giachritsis, Dr Fiona Gillison and Dr Kate Rimes thank you for your encouragement, kindness and for being such inspiring role models.

Lucy Clarkson and Amanda Brooks for your enthusiasm, support and input.

My clinical tutees and research trainees for their encouragement and support and my colleagues on the University of Bath DClin Programme.

Professor Steve Gough, thank you for your compassion and wisdom, you made a huge difference to my life. Thanks also to Caroline Ransford, John Brice and Andrea Baker in the Doctoral College.

Mum thank you for believing in me and for supporting me in all the ways anyone possibly could. Thank you for your ongoing encouragement to finish this, I am so grateful for your unconditional love, support and WhatsApp chats. Gen, thank you for sister-ship throughout.

To my Dad, who was very supportive of me, who I miss daily. I so wish you were still here so that amongst many other reasons, you could see that I finally finished it!! But I hope, perhaps somehow, you might know.

Thank you also to Joan for encouraging me to go back to England to finish my studies after my dad passed and for your belief in me. I hope perhaps you are both up there looking down together, I know you would also be pleased.

To my second set of parents Mary and David, thank you for your encouragement throughout this process. A special thank you to Mary for proof reading several of my chapters and for your kind, thoughtful and encouraging feedback.

To Aunty Shirley, thank you for all your calls from the states to check if I had finished yet! and for all your kind encouragement. Bronny, Katie and all my extended family back in Australia.

My examiners - if you have got this far! Thank you for taking the time to read my thesis. I look forward to meeting with you soon.

Last, but of course not least, my husband Julian. Thank you for all your support. Words cannot express the love and gratitude I have for you.

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List of Tables[2]

[2] **Please note**. Due to study chapters being presented as manuscripts, table numbers are not organised sequentially. Each paper includes its own sequential table formatting.

List of Figures[3]

[3] Due to study chapters being presented as manuscripts, the numbers of figures are not organised sequentially. Each paper includes its own sequential figure formatting.

CHAPTER 1 – INTRODUCTION AND THESIS AIMS

Obsessive Compulsive Disorder (OCD) is a mental health problem characterised by the presence of obsessions (i.e. recurrent and persistent thoughts, images or urges that are intrusive, unwanted and cause significant distress or anxiety) and/ or compulsions (i.e. repetitive behaviours or mental acts that are carried out in response to obsessions) (American Psychiatric Association, 2013). There is a reported life time prevalence of between 1 to 3% (Kessler et al., 2005; Torres et al., 2006). In the absence of appropriate treatment its course is chronic, leading to significant costs for the individual sufferer in terms of significant life impairment and disability (Asnaani et al., 2017; Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009; Sahoo, Sethy, & Ram, 2017), as well as significant economic costs (DuPont, Rice, Shiraki, & Rowland, 1995; Hollander et al., 1997). OCD (amongst other disorders) has been ranked the 6th largest contributor globally to "non-fatal health loss" by the World Health Organisation (WHO, 2017). OCD is also in the category of the top ten causes of years lost to disability within all WHO regions (WHO, 2017).

In response to the significant costs and burdens, the past five decades have seen the psychological treatment of OCD revolutionised (Foa & Kozak, 1996; Rachman, 1997; Rachman, de Silva, & Röper, 1976; Salkovskis, 1985, 1999). OCD has been transformed from a poorly understood and poorly treated disorder to one that can be successfully treated with evidence-based psychotherapy, namely Cognitive Behavioural Therapy (CBT) which includes Exposure and Response Prevention (ERP)[4] (Öst, Havnen, Hansen, & Kvale, 2015). Despite the substantial developments in efficacious treatments, a significant proportion of those affected by OCD (approximately 38%) do not respond to treatment (Öst et al., 2015). For these individuals' OCD often continues to severely interfere with their daily lives and functioning. This indicates that as a field we have further work to do, both in further developing our understanding of why these individuals do not respond to CBT and by further exploring what approaches can be taken to help improve these patients' outcomes.

The study of treatment failure is central to understanding why a significant proportion of individuals fail to benefit from efficacious interventions. However, to date the predominant focus of this work has been undertaken from the perspective of health care organisations providing services. The perspective of the patient in understanding why CBT

[4] Cognitive Therapy (CT) (including elements of exposure) and Exposure and Response Prevention (ERP) (a form of behaviour therapy) do not differ significantly in clinical outcome (Öst et al., 2015). Thus, for the purposes of this thesis they will be referred to synonymously as CBT.

may fail has not been thoroughly explored; despite its clear value in advancing our understanding and thus potential effectiveness of treatment. An investigation of the views of those who have a lived experience of treatment failure is therefore required.

The National Institute for Health and Care Excellence (NICE) adopts the 'stepped care' model of treatment recommendations for OCD based on the current available evidence. Within the final 'step' of treatment recommendations for OCD, for those who have not responded to previous CBT, an intensive version of treatment is recommended. Research has explored this treatment format somewhat, again predominantly from the perspective of the health care provider. Some research indicates that an intensive approach is acceptable to some service users (Bevan, Oldfield & Salkovskis, 2010). However, whether it is acceptable to those for whom the recommendation is in place (i.e. service users with multiple CBT failures) has been overlooked. Thinking beyond the recommendations of NICE to the practical implementation of intensive treatment in National Health Service (NHS) settings, how widely intensive treatments are being utilised is currently unknown. It is well established that the views of therapists regarding the treatment they provide can have an impact on the patient and potential therapeutic outcome (Dew & Bickman, 2005). Thus, the views of the therapist delivering the treatment are important yet are unknown with regards to intensive CBT.

To advance our understanding it is essential to consider all perspectives and most importantly those on the front line, that is, service users' and therapists'. In addition, the state of the evidence base underpinning this recommendation is unclear. On the premise that the only evidence-based psychological treatment for OCD is currently helping only three in five service users, leaving a significant proportion severely impaired leads to the focus of this thesis. This thesis centres on those who have not responded to standard CBT having experienced $\geq$ 2 CBT failures and explores participants' perceptions of why this might be. In addition, this thesis focuses on the perceptions of both patients' and therapists' regarding intensive CBT as a treatment format option.

To consider the issues outlined above the research of this thesis has the following aims:

1) To explore the current understanding of OCD as a disorder including its impact on the sufferer and the evolution of treatment (Chapter 2).
2) To gain an understanding of and to critically evaluate the treatments being recommended and or used for OCD (Chapter 3).

3) To systematically evaluate the evidence-base on which the NICE recommendation of an intensive treatment is based (Chapter 5).
4) To gain and in-depth understanding of the experience of multiple treatment failures and the reasons for this from the perspective of the service user (Chapter 6).
5) To examine the treatment option of CBT delivered in an intensive format from the perspective of the service user and therapist (Chapter 7 and 8).
6) To examine OCD participants' preferences for the format in which CBT is delivered (Chapter 9).
7) To gain an in-depth understanding of the experience of relapse after successful intensive or standard CBT (Chapter 10).

Thesis structure[5]

The research aims as outlined will be addressed and discussed in the chapters of this thesis. The structure in which this will occur is presented as below. Figure 1 illustrates the flow and connection between the chapters of this thesis.

Chapter 1 provides an introduction to and overview of this thesis and its aims.

Chapter 2 presents a review of the literature that provides a background for the empirical studies of this thesis and the theoretical perspectives utilised. In line with the first aim of this thesis, it discusses the phenomenology and epidemiology of OCD and the research evidence relevant to our current understanding of OCD. Given there is evidence that those suffering from OCD often delay in seeking help, the barriers related to this and the consequent implications of this for the sufferer are considered.

Chapter 3 To address the second aim of this thesis Chapter 3 provides a review of the treatment options available for OCD within the 'stepped care' framework outlined by NICE. It considers the treatment options recommended for those who have not responded to treatment. Thus, it introduces the focus on the under researched but recommended format of intensively delivered CBT. This chapter also considers the measures of desperation that some service users are drawn to after evidence-based treatments have failed them. Thus, it considers treatment options that are not evidence-based nor recommended but utilised. After reviewing the different treatment options available, this chapter concludes that the most promising avenue for further exploration is intensive CBT. Nevertheless, this treatment format has received little research attention, thus the rationale for further research is clear.

Chapter 4 presents Study 1, a systematic review which examines the evidence-base for intensive CBT for adults with OCD.

Chapter 5 To achieve the aims of this thesis a mixed methods approach was utilised. This chapter provides an overview of the epistemological and ontological stance adopted. An outline of the author's background and reasoning for the choice of methods and theoretical lens is presented.

Chapter 6 Before exploring service users' views on the possible solution of an intensive version of CBT, it is important to understand their views on why weekly treatment

[5] **Please note:** This thesis adopts an alternative format comprising of manuscripts. As described by the University of Bath's doctoral QA7 regulations, each academic paper will have self-contained components that may overlap with other thesis sections or duplicate some material already presented. Separate reference lists are provided for each study manuscript. All other thesis chapter citations are referenced in a final overall reference list.

failed them. Therefore, this chapter reports on an exploratory study conducted to gain an understanding of treatment failure from the perspective of the service user (*N* = 12). This study provides insight into factors perceived to contribute to treatment failure that are similar to those that have been reported by therapists, but the reasons underlying these factors are different (e.g. the reasons for the underuse of evidence-based components of therapy such as ERP differ).

Chapter 7 provides a qualitative analysis of participants' (*N* = 30) experiences of, or views on, the prospect of undertaking CBT in an intensive format of CBT.

Chapter 8 follows on from Chapter 7 by exploring therapists' (*N* = 132) experiences of, or views on, the prospect of delivering CBT in an intensive format. Through a mixed-methods design, the study presented here reports on the therapists' views and willingness to adopt an intensive format of CBT delivery.

Chapter 9 builds on the findings from the three previous chapters to develop a questionnaire that is used in this study to examine OCD participants' (*N* = 235) preferences for treatment format from both a practical and therapeutic perspective.

Chapter 10 draws on the concerns raised in Chapters 6 and 7 regarding the possibility of treatment gains being achieved quickly in intensive CBT, but also being lost quickly after therapy. It does this by examining participants (*N* = 27) experience of relapse after successful CBT which was undertaken in either an intensive or weekly format.

Chapter 11 provides a general discussion of the main findings and clinical implications from the chapters as outlined above. Limitations of the research are considered along with suggestions for future research.

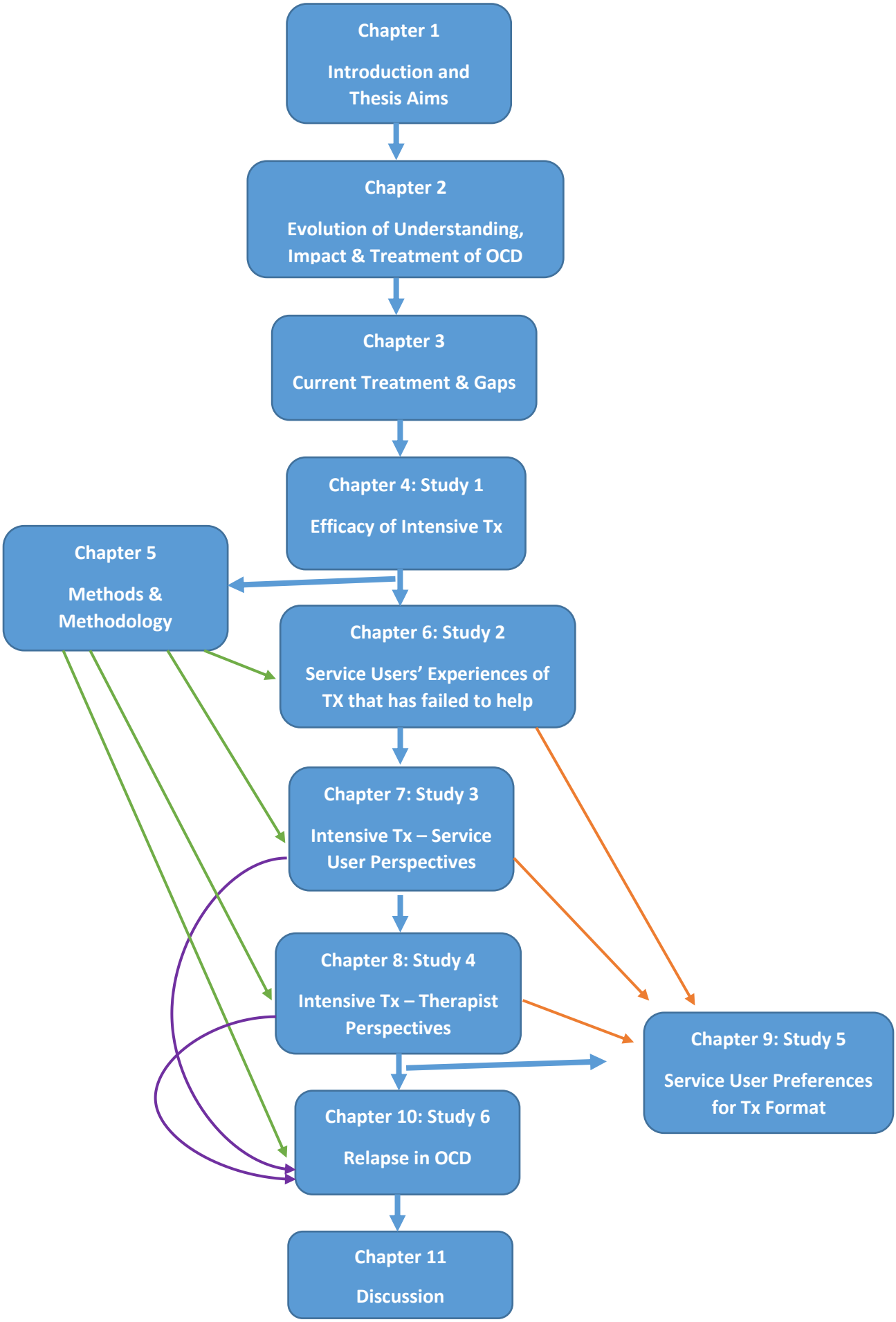

Figure 1. Flow diagram depicting how the Chapters and Studies are informed by and related to each other. *Note:* Tx = Treatment.

CHAPTER 2: LITERATURE REVIEW - PART ONE

How the Understanding of OCD and Its Treatment Has Developed

"I thought there was something seriously wrong with me, like really terribly bad and wrong, it wasn't until I read about OCD, that I realised what I had was actually only an anxiety problem […] I wasn't going completely mad" (OCD participant- study 1).

Chapter Rationale

As suggested in the introduction to this thesis, OCD has not always been well understood. Considering the variations in how obsessive-compulsive symptoms have been conceptualised provides an important foundation for the context of our current understanding and the development of subsequent treatments. This chapter will therefore begin with a review of the origins of the concept of OCD and its evolution in line with the underpinning theories. This will set a backdrop for examining the epidemiology of OCD. This chapter will show that OCD is a common and serious problem and will discuss how the seriousness of the problem relates to the comorbidity and the course of the disorder. It will be shown that none of the current treatments are completely effective for all, and that although literature suggests that patients whose symptoms are more severe at the outset do less well in treatment, some research in this area indicates uncertainty in such a conclusion. This chapter will conclude by highlighting the need to further evaluate and refine treatments to aid efficiency, providing a segue for an examination of treatment options under the umbrella of the NICE guidelines in Chapter 3.

CHAPTER 2: LITERATURE REVIEW – PART ONE

How the Understanding of OCD and Its Treatment Has Developed

Phenomenology of OCD

Origins of OCD

From the earliest times until very recently, OCD has been considered puzzling and fundamentally abnormal. Descriptions of what is now recognised as OCD can be traced back through the centuries. The earliest descriptions are more commonly documented in religious rather than medical texts. In the 7th century AD the case of a young monk being continuously troubled by 'temptations of blasphemy' is recorded (Osborn, 1999). From the 14th to the 16th century, those who experienced obsessive thoughts which were blasphemous or sexual in nature were believed to be possessed by the devil (Aardema & O'Connor). Treatment therefore involved exorcism. In the 16th century Shakespeare describes a case of mental (rather than contact) contamination in Macbeth, where Lady Macbeth is seen washing repeatedly in an attempt to remove moral blemishes (Elliott & Radomsky, 2009). In the 17th century a religious framework dominates explanations for obsessive-compulsive with symptoms being described as 'religious melancholy' (Osborn, 1999). In 1660 the Bishop of Down and Connon, Ireland, referred to obsessional doubting when he wrote of 'scruples', describing this as "trouble where the trouble is over, a doubt when doubts are resolved" (Osborn, 1999). In the 18th century OCD was described as a form of 'monomania' or 'partial insanity' and attributed to having a disordered intellect (Berrios, 1989). In the 19th century OCD is described in the psychiatric literature as several variants of insanity including 'impulsive insanity', 'insight neurosis' and 'psychosis of degeneration' proposedly due to 'defective heredity' (Berrios, 1989). Morel (1866) placed OCD in the category of 'emotional diseases' suggesting a problem with the autonomic nervous system due to the presentation of anxiety accompanying the symptoms and is the first to use the term 'obsession' (Berrios, 1989). In the 20th century the first psychological view of OCD is described by Janet (1903) who attempts to delineate a syndrome. It was also around this time that Freud became interested in OCD, describing it as 'obsessional neurosis' (Berrios, 1989). Freud identified the inner world of the child as the source of obsessional neurosis, suggesting that such individuals had regressed from oedipal to anal sadistic ways of dealing with themselves and their objects (O'Connor, 2008). Freud also considered it to be a 'pre-psychotic state', where weak ego boundaries resulted in the contents of the Id intruding into the ego. Compulsions were seen as a defence mechanism which strengthened the ego boundary and thereby

prevented the sufferer from descending into madness (O'Connor, 2008). In the later 20th century we see a progression towards acceptance of mental health problems and the development and evolution of a diagnostic classification system in which OCD was regarded as an anxiety disorder.

Diagnostic definitions of OCD

In 1921 the American Psychiatric Association (APA), in collaboration with the New York Academy of Medicine developed the first US nationally accepted psychiatric classification system. This was primarily designed for diagnosing inpatients presenting with severe psychiatric and neurological problems (APA, 2019). Following World War II, a broader classification system was developed, predominantly in response to the outpatient presentations of veterans this included several categories (i.e. psychophysiological, personality, and acute disorders). In parallel timing, and significantly influenced by veteran's administration, the World Health Organisation (WHO) for the first time, included a classification of mental health disorders published in the sixth edition of the International Classification of Diseases (ICD) (including 10 categories for psychoses and psychoneuroses and seven for disorders of character, behaviour, and intelligence). It was in 1952 that the APA published a variant of the ICD-6 as the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), an official manual of mental disorders with a focus on clinical use, including descriptions and diagnostic categories (APA, 2019). However, it was not until 1980 that substantial innovations occurred, with the publication of DSM-III. Developments included a multiaxial diagnostic assessment system, specific diagnostic criteria and a neutral approach to the aetiology of mental disorders. This was accompanied by the introduction of the psychiatric interview developed for research and clinical use. Following this ICD-9-CM (clinical modification) was published also including a clinical and research application. Specific diagnostic criteria for OCD was first listed in DSM-III. Revisions in DSM-IV-TR (APA, 2000) led to OCD being grouped with the 'anxiety disorders', with further revisions to the criteria and classification most recently in DSM- 5. Table 1 details the initial diagnostic criteria and subsequent alterations.

OCD is defined as consisting of obsessions *or* compulsions that are time-consuming (i.e. consuming more than one hour per day) or cause marked distress, anxiety or impairment. Obsessions are defined as intrusive and persistent thoughts, images or impulses that cause the individual anxiety and or distress. Compulsions are defined as repetitive behaviours or mental acts that are carried out in response to obsessions to reduce anxiety or distress and are not pleasurable to the individual performing them (APA, 2013). It is

important to note that the diagnosis of OCD is dependent on the distress and disability that the symptoms cause, not just the occurrence of the symptoms themselves.

Table 1.
Changes to OCD DSM criteria

Version and Year	Diagnostic Criteria
DSM-III (1980), DSM-III- R (1987)	Either obsessions or compulsions: **Obsessions: (1), (2), (3) and (4):** 1. Recurrent and persistent ideas, thoughts, impulses or images that are experienced, at least initially, as intrusive and senseless, e.g., a parent's having repeated impulses to kill a loved child, a religious person's having recurrent blasphemous thoughts 2. The person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action 3. The person recognizes that the obsessions are the product of his or her own mind, not imposed from without (as in thought insertion) 4. If another Axis I disorder is present, the content of the obsession is unrelated to it, e.g., the ideas, thoughts, impulses or images are not about food in the presence of an Eating Disorder, about drugs in the presence of a Psychoactive Substance Use Disorder or guilty thoughts in the presence of a Major Depression **Compulsions: (1), (2) and (3):** 1. Repetitive, purposeful and intentional behaviours that are performed in response to an obsession or according to certain rules or in a stereotyped fashion 2. The behaviour is designed to neutralize or to prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive 3. The person recognizes that his or her behaviour is excessive or unreasonable (this may not be true for young children; it may no longer be true for people whose obsessions have evolved into overvalued ideas) The obsessions or compulsions cause marked distress, are time-consuming (take more than an hour a day), or significantly interfere with the person's normal routine, occupational functioning or usual social activities or relationships with others.
DSM-IV (1994)	A. Either obsessions or compulsions: **Obsessions as defined by (1), (2), (3), and (4):** 1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress 2. The thoughts, impulses, or images are not simply excessive worries about real-life problems

	3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action 4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion) **Compulsions as defined by (1) and (2):** 1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly 2. The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships. D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of major depressive disorder) E. The disturbance is not due to the direct physiological effects of substance (e.g., a drug of abuse, a medication) or a general medical condition Specify if: With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable
DSM-5 (2013)	As detailed above in DSM-IV with the following changes; **Obsessions as defined by two criteria** (*criteria 2 and 4 from above have been removed*) The following descriptive words were have been altered in criteria 1 • The definition of "urge" was changed to "impulse". • The word "inappropriate" was changed to "unwanted" (This alteration was made in an effort to make the description more widely and

	culturally understood. It is suggested that the meaning attached to the word "inappropriate" may vary with culture, age and gender) . (Abramowitz & Jacoby, 2014; Leckman et al., 2010). • An insight specifier and the tic-related specifier are now included.

The DSM-5 states that the presence of *either* obsessions *or* compulsions is necessary for diagnosis (APA, 2013), which led to the consideration by some that these symptoms are distinct (Hollander, 1993). However, psychological approaches highlight the defining feature of OCD as the *functional relationship* that exists between obsessions and compulsions. That is, the key role that the carrying out of compulsions has in the *maintenance* of obsessions. In psychological conceptualisations, compulsions are carried out in *response* to the obsession, and are effective by transiently relieving associated anxiety/ distress which consequently perpetuates the obsession (Salkovskis, 1985; Salkovskis, Westbrook, Davis, Jeavons, & Gledhill, 1997). Consistent with this assumed interplay, studies utilising large samples of participants with a diagnosis of OCD, report almost unanimously the co-occurrence of obsessions and compulsions (Foa et al., 1995; Leonard & Riemann, 2012). The existence of a 'pure obsessional' subtype is now better explained by recognising the presence of covert compulsions (Salkovskis and Westbrook, 1989; Williams et al., 2011). Studies examining the latent structure of OCD symptoms have shown that some dimensions are comprised of both obsessions and compulsions (e.g. contamination obsessions and washing compulsions), demonstrated by the loading of both obsessions and compulsions on the same symptom-based factors (Abramowitz, Franklin, Schwartz, & Furr, 2003; Leckman et al., 1997; McKay et al., 2004).

Over time the emphasis that DSM has placed on the 'repetitiveness' of symptoms has led to confusion regarding *repetition* as a central construct to defining OCD. Concepts such as 'OCD spectrum disorders' have thus been derived, which focus on the existence of any repetitive symptom without considering the *functional* interplay between obsessions and compulsions (Hollander, 1993). Some researchers have hypothesised that OCD occurs within the framework of a spectrum of related disorders which include tic disorders, anorexia nervosa, trichotillomania, body dysmorphic disorder and conduct disorders (Hollander & Benzaquen, 1997). It is proposed that "obsessive compulsive spectrum disorders can be traced to similar patterns of intrusive, senseless and irrational obsessions, and/or ensuring compulsions or impulses to perform rituals or repetitive behaviours" (Hollander & Benzaquen, 1997, p. 107). The validity of the concept of an OCD spectrum of related disorders has been questioned (Kozak, 1999). However, despite significant debate (Stein et

al., 2010; Thomsen, 2013), OCD was reclassified in DMS-5. OCD was removed from the category of 'anxiety disorders' and placed into a new diagnostic category titled 'Obsessive-Compulsive and Related Disorders' (OCRDs) (APA, 2013). This new category was devised to group disorders which are characterised by the presence of obsessive thoughts and/ or repetitive behaviours (APA, 2013). The OCRD category includes: OCD, Body Dysmorphic Disorder (BDD), Hair-Pulling Disorder (formerly trichotillomania; TTM) and the new diagnostic entities of Excoriation (skin-picking) disorder, Hoarding Disorder, and Other Specified and Unspecified OCRDs (APA, 2013). The APA state that the grouping is a result of "increased evidence of these disorders' relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter" (APA, 2013, p. 235).

Besides the reclassification of OCD, the key changes to diagnostic criteria in DSM-5 that are likely to have clinical implications are the changes to OCD specifiers which capture potential variation in the manifestation of this problem. These include *insight* and a *tic-related* specifier (Van Ameringen, Patterson, & Simpson, 2014). Of particular relevance to treatment non-response is the specifier of insight. Poor insight has long been associated with severity in OCD symptoms (Catapano et al., 2010; Kishore, Samar, Reddy, Chandrasekhar, & Thennarasu, 2004) and has been identified as an independent predictor of poor outcome (Visser et al., 2017).

In previous DSM definitions of OCD individuals were required to recognise their obsessions as a product of their own mind and to hold a view of their obsessions and compulsions as unreasonable or excessive. In DSM-5 there is acknowledgment that individuals vary in their conviction of obsessional fears, and clinicians are now required to assess the individuals' degree of insight on a three-criterion scale (a) 'good or fair insight', (b) 'poor insight' or (c) 'absent insight/ delusional beliefs' (APA, 2013). A small proportion (approx. 2 - 4%, Visser et al., 2017; Foa, et al., 1995) who are convinced of the veracity of their obsessions, appearing to have delusion-like beliefs, may nonetheless warrant a diagnosis of OCD rather than for example a psychotic disorder. The concept of 'overvalued ideas' had previously been invoked to explain this phenomenon (Foa, 1979; Foa et al., 1999; Veale, 2002).

The reclassification of OCD has provoked much debate in relation to both empirical and conceptual considerations from researchers and clinicians alike (Phillips et al., 2010; Stein et al., 2010; Storch, Abramowitz, & Goodman, 2008). Abramowitz and Jacoby (2014) eloquently outline further scientific arguments for and against the change along with further

potential implications for clinical practice and research. They review the literature and conclude that empirical research accompanied by clinical observations is persuasive in evidencing that OCD is more similar to anxiety disorders than to the other disorders included in the diagnostic category of OCRD's (with the exception of BDD).

The potential problems of conceptualising OCD within a spectrum of disorders should be noted, particularly with reference to treatment of OCD. The understanding and application of theoretical models which apply to the treatment of OCD are imperative (i.e. that highlight the *functional* relationship between obsessions and compulsions). If these are not understood or are incorrectly applied to other disorders this could impact both on the perception of how treatable OCD and other disorders are (Kozak, 1999).

While the above has discussed the evolution of the diagnostic system for mental health problems, with reference to the DSM, the diagnostic system utilised within the UK and continental Europe is the International Classification of Diseases (ICD) (WHO, 2016). Within the ICD-10, OCD is classified in 'Chapter V Mental and Behavioural Disorders' Code F42.9. Table 2 highlights the similarities and differences between the diagnostic criteria outlined in ICD-10 and DSM-5.

The ICD-10 criteria for mental and behavioural disorders have been under review with the key aim of improving their clinical utility and global applicability. In ICD-11 the defining features of OCD are to remain the same. Similar to DSM-5 new OCD subtypes have been proposed, to address the heterogeneous ways that OCD can present (Simpson & Reddy, 2014). It is expected that ICD-11 with be released for use in January 2022.

Table 2

Similarities and differences between ICD-10 and DSM-5

	ICD-10	**DSM-5**
Defining Obsessions & Compulsions	Other than defining Obsessions as "thoughts" and Compulsions as "behaviours," the definition is shared.	Separate definitions of Obsessions and Compulsions with functional relationship. Compulsions can be mental rituals.
Symptom duration	Most days for ≥ 2 weeks.	No criteria
Response	Requires at least one Obsession or Compulsion to be unsuccessfully resisted. Explicitly not pleasurable	Obsessions "in most individuals cause marked anxiety or distress" "attempts to ignore, suppress or to neutralize" Obsessions… (i.e., by performing a compulsion)
Impairment	Distress or interference with activities	Time-consuming (e.g., > 1 hour/day) or cause

	ICD-10	DSM-5
		clinically significant distress or functional impairment
Insight	"They must be recognized as the individual's own thoughts or impulses"	Range of insight permitted
Exclusion	Specific rules about diagnosing OCD with depressive disorders; cannot diagnosis OCD in those with schizophrenia or Tourette syndrome	Differentiates OCD from a number of Axis I disorders. Allows OCD to be diagnosed with depressive disorders, schizophrenia, and Tourette syndrome. Specifically, allows OCD to be diagnosed even in the presence of delusional OCD beliefs.
Physiological cause	Exclusion: "organic mental disorder"	"Not attributable to the direct physiological effects of a substance…or another medical condition"
Specifiers	1)Predominantly Obsessions 2)Predominantly Compulsions 3)Mixed Obsessions & Compulsions	1)Insight (good/fair vs. poor vs. absent- delusional) 2)Tic-related

In summary our understanding of OCD has progressed significantly and is now understood as a psychological problem. We now turn to examine the impact of this problem and how pervasive it is by examining the epidemiology of OCD.

Epidemiology of OCD

Prevalence

The Epidemiology Catchment Area (ECA) survey (Karno, Golding, Sorenson, & Burnam, 1988) was the first study to document epidemiological data for OCD, utilising the Diagnostic Interview Schedule (DIS) to establish DSM-III diagnosis. It reported a lifetime prevalence of OCD of 2.5% (range 1-3%), with a one-year prevalence of 1.3%. The reported figures were 25 to 60 times higher than what had been previously estimated (Karno et al., 1988). This study was pioneering, as prior to this OCD had been considered a relatively rare disorder, with the earliest study conducted by Roth and Luton (1943) estimating 0.3% and later Rudin (1953) estimating a smaller prevalence of 0.05% (Fontenelle, Mendlowicz, & Versiani, 2006).

Subsequently, a large cross national epidemiological study that examined OCD prevalence rates in six countries (i.e. Canada, Germany, Korea, New Zealand, Pueto Rico and Taiwan) was conducted (Weisman et al., 1994). Similar methods were utilised, and the results were consistent with the ECA study (life time prevalence of 1.9% to 2.5%, except for Taiwan, which reported a much lower prevalence rate of 0.4%) (Weisman et al., 1994).

However, in 1997 a review of the epidemiological evidence criticized the methodology used, stating that the DIS had poor validity and suggested that the estimates were likely to be inflated, concluding that the true prevalence of OCD was unknown (Nelson & Rice, 1997). Since this review several epidemiological studies have been conducted with focus being given to methodological rigour. The largest UK study to date; The British Psychiatric Morbidity (BPM) Survey of 2000 (Torres et al., 2006) used the Clinical Interview Schedule-Revised (CIS-R) to assess a sample of 8580 for OCD. This study reported a weighted prevalence of 1.1%. However, the US National Comorbidity Survey (NCS) (Ruscio, Stein, Chiu, & Kessler, 2010) which employed similar methodology, reported findings more consistent with the initial ECA study. A lifetime OCD prevalence of 2.3% was reported, with over a quarter of participants reporting a subclinical history of obsessions or compulsions.

To date there have been approximately 36 individual studies conducted globally that have investigated the prevalence of OCD. These studies have produced 60 estimates of prevalence, with 24 of these being estimates of lifetime prevalence (Coles, Wirshba, Nota, Schubert, & Grunthal, 2018). Despite variations in findings, the overall consensus is that OCD is not uncommon with the lifetime prevalence being between 1 - 3% (Ruscio et al., 2010). The estimated prevalence of subclinical Obsessive-Compulsive syndromes is between 7 - 25% (Fineberg et al., 2013; Fullana et al., 2009, 2010).

Demographic Factors

Sex and age of onset.

Prevalence rates for OCD have been found to be higher in women. The BPM study (Torres, 2006) revealed a prevalence of 1.4% amongst women and 0.9% among men. The onset of OCD commonly occurs in childhood or adolescence, with most cases of OCD occurring before the age of 18 years (Dell'Osso et al., 2016; Fineberg et al., 2013).

The prevalence of OCD has been shown to decrease with increasing age. For example, within the BPM study (Torres, 2006) among those in the 16 - 24 year age group the prevalence was 1.3%, for those aged 25 - 44 years 1.1%, 45 - 64 years 0.2% and 65 - 74

years 0.2%. For those who develop OCD as children or young people, OCD interferes throughout the sensitive and critical periods of their development leaving them at risk of life-long impairments (Fineberg et al., 2019).

Co-morbidity and Course

It is well documented that individuals with OCD have increased levels of comorbidity. Large cross-continental studies have reported high rates of comorbidity particularly with major depression and anxiety disorders (Brakoulias et al., 2017). Generalised anxiety disorder, specific phobia and social phobia have been found to be amongst the three most frequently co-occurring anxiety disorders (Brakoulias et al., 2017).

The BPM study (Torres, 2006) found that 62% of individuals with OCD in the UK had one or more comorbid conditions (Torres et al., 2006). For these individuals the most common comorbidity was a depressive episode (36.8%) followed by generalised anxiety disorders (31.4%), agoraphobia or panic disorder (22.1%), social phobia (17.3%) and specific phobia 15.1% (Torres et al., 2006).

Without appropriate treatment OCD is very unlikely to remit. A two year prospective follow-up study on the course of OCD found the probability of full remission 6% and partial remission 24% (Eisen et al., 2010).

Help Seeking

The duration of which OCD remains untreated is one of the highest amongst mental health problems (Altamura, Buoli, Albano, & Dell'Osso, 2010). A number of studies suggest that the duration of untreated OCD (rather than early onset itself) is associated with poorer treatment outcomes, functional impairment and disability and increased co-morbidity (Albert et al., 2019; Dell'Osso et al., 2013; Dell'Osso et al., 2016; Lomax, Oldfield, & Salkovskis, 2009).

From studies conducted in different parts of the world it is estimated that between 38% and 89% of individuals do not seek help or do not receive help for OCD (Chong et al., 2012; Marques et al., 2010; Mayerovitch et al., 2003; Subramaniam, Abdin, Vaingankar, & Chong, 2012; Torres et al., 2007). Those who do seek help take between three and 17 years to seek and receive appropriate treatment (Belloch, del Valle, Morillo, Carrió, & Cabedo, 2009; Pinto, Mancebo, Eisen, Pagano, & Rasmussen, 2006). On average a minimum delay of at least 10 years is reported (Albert et al., 2019). A review of the help seeking literature does not provide a clear picture with regards to who is likely to seek help. Instead the

evidence is somewhat mixed with a combination of facilitators and barriers described to be in play (Garcia-Soriano et al., 2014). These are outlined below.

Socio-demographic variables related to help seeking.

Very few studies have reported associations between socio-demographic variables and help seeking behaviour. With respect to age, the results across studies are inconsistent, one of 10 studies found that women seek help around three years earlier than men (Stengler et al., 2013); two of six studies found positive associations between being married and help seeking (Demet et al., 2010; Goodwin et al., 2002); one of three and one of two studies (respectively) found that a moderate income level (compared to high) and full time employment were negatively associated with help seeking (Demet et al., 2010; Goodwin et al., 2002), and one of six studies found a higher education level is associated with a greater delay in help seeking (Belloch et al., 2009). There is a very small amount of research on ethnic minorities (Williams, Proetto, Casiano, & Franklin, 2012). The research that has been done has shown that individuals from ethnic minorities are less likely to seek help (Goodwin et al., 2002), may seek help from their GP rather than a mental health professional (Neighbors, 1988), or may present at specialist physical health clinics, such as dermatologists (Friedman, Hatch, Paradis, Popkin, & Shalita, 1993).

OCD symptoms and help seeking.

The evidence for the relationship between specific OCD variables and help seeking is more conclusive. Help seeking or undertaking of treatment is associated with; higher levels of impairment (Cullen et al., 2008), interference (Belloch et al., 2009) and worse perceptions of quality of life (Beşiroğlu, Çilli, & Aşk, 2004). In some studies help seeking was associated with greater symptom severity (Beşiroğlu et al., 2004; Ruscio et al., 2010); greater insight (Belloch et al., 2009; Beşiroğlu et al., 2004; Demet et al., 2010); a greater number of obsessions (but not compulsions) (Cullen et al., 2008; Mayerovitch et al., 2003); and the content of the obsession being particularly violent, aggressive or religious in nature (Beşiroğlu et al., 2004; Markovich et al., 2003). The most consistently reported predictor of help seeking is comorbidity of mental health difficulties (Beşiroğlu et al., 2004; Cullen et al., 2008; Fullana et al., 2009; Goodwin et al., 2002; Mayerovitch et al., 2003; Torres et al., 2007). Torres et al. (2007) reported that 55.6% of individuals with comorbid OCD sought and received help in comparison to 13.9% with OCD alone.

Help seeking: 2019 Expert consensus statement.

Due to the risks and negative outcomes associated with delays in treatment, the reduction of the duration of untreated illness (DUI) is a priority. Fineberg and colleagues (2019) recently published an expert consensus statement focusing on early interventions for OCD. The team of experts comprised a total of 40 neuroscientists, psychiatrists, psychologists or clinicians with expertise in OCD and an individual with lived experience. The statement draws attention to the chronicity of OCD and utilises epidemiological, clinical, health economic and brain imaging studies to highlight the personal and healthcare costs associated with DUI to emphasise the importance of early intervention.

The consensus statement proposes that psychoeducation be widely implemented to improve awareness and knowledge about the disorder. The authors suggest that an illness staging model be applied to OCD, seeking to predict the course of the disorder in order to limit its progression. The strategic application of such a model, is posited, to help to identify those at risk of developing the disorder. It is suggested that this should be informed by research into the symptomology of OCD alongside contextual information about the patient. It is proposed that this information should include genetic and environmental factors, with recent studies demonstrating the significant role of the latter (Fineberg et al., 2019).

Impairment and Burden of OCD.

As mentioned above it is well documented that individuals with OCD experience significant and persistent impairment (Ruscio et al., 2010; Stein, 2002). The effect that OCD has on an individual's daily living and capacity to function is often extensive and multifaceted. In the NCS study (Ruscio et al., 2010) individuals reported spending an average of 5.9 hours per day engaged with obsessions and 4.6 hours a day carrying out compulsions. Individuals with OCD are estimated to lose between 25 to 45 days per year from their daily roles due to OCD (Ruscio et al., 2010; Subramaniam et al., 2012). It is not surprising that within epidemiological studies 74.5% of those with OCD reported interference at work and 59.4% reported considerable interference in social activities (Torres, 2006). In comparison to individuals with conditions excluding OCD, individuals with OCD and comorbid conditions are less likely to be married, more likely to be unemployed and more likely to have low income levels and low occupational status. It is suggested that these factors are likely to be independent of other psychological comorbidities and instead attributable to OCD (Torres, 2006). Since 1990 the World Health Organisation (WHO) has recognised the significant burden associated with OCD (WHO, 1996, 2017).

Quality of life.

Quality of life for children, young people (Storch et al., 2018) and adults with OCD is unsurprisingly negatively affected (Fontenelle et al., 2010; Pozza, Lochner, Ferretti, Cuomo, & Coluccia, 2018). Longer duration and symptom severity have both been associated with poorer quality of life (Dell'Osso et al., 2013). OCD has previously been found to be the most severe 'anxiety disorder' [6] with 50.6% of cases categorised as 'serious' within a 12-month period, in comparison to 22.8% of anxiety disorders (when considered as a group) (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Twenty six percent of individuals with OCD reported attempting suicide at least once in their life which is almost double of that reported by individuals with other psychological conditions and 10 times more than individuals with no reported condition (Torres et al., 2006).

In summary OCD is not uncommon, it often occurs early in an individual's life and can be highly comorbid. Help seeking is most commonly significantly delayed. Without appropriate treatment, the course of OCD is both chronic and debilitating. As such we now turn to examine the development of treatments for OCD.

The Development of Evidence-Based Treatments for OCD

Behavioural Theory of OCD

The basic underpinnings of the first successful approaches to the treatment of OCD were based firmly in Behavioural Theories of Anxiety. Behavioural theory in psychological terms was the turning point for the contemporary understanding of OCD and the development of effective treatments.

The two process behavioural model of OCD (Mowrer, 1947, 1960) proposed that obsessions are neutral stimuli that have become associated with anxiety through the process of classical conditioning. The association is perpetuated and reinforced via operant conditioning of subsequent responses such as avoidance. In 1958 Wolpe developed the theory of reciprocal inhibition from which the technique of systematic desensitisation was based and used to treat OCD. In this treatment patients were asked to use their imagination to face their feared stimuli, whilst relaxation techniques were applied to reduce anxiety via counter conditioning.

In 1966 Meyer proposed that exposure to the feared stimuli *in-situ* with response prevention was essential and that this strategy would allow the patient to habituate to their

[6] Although DMS-5 no longer categorises OCD as an 'anxiety disorder, the re-categorisation only took place in 2013. Research conducted prior to this date refers to OCD as an anxiety disorder and thus is referred to as such when such research is reported.

anxiety and modify their expectancies regarding the feared stimuli, by discovering that the feared consequence did not eventuate. Meyer was influenced by the 'flooding' methods that had been utilised to extinguish fear in animals and this underpinned his initial approach to treatment (Rachman, 2009). Meyer (1966) first successfully treated two patients with severe and protracted OCD utilising an intensive method of behaviour therapy in an inpatient setting. Meyer employed a 'total' treatment design which involved the patient exposing themselves to situations or items that caused them the most distress. Meyer then prevented the patients from carrying out any of their compulsions. He did this by turning off the water supply to the patient's room to prevent washing rituals and having the patient closely monitored by nursing staff (supervised by Meyer). The nurses provided verbal support and encouragement (Rachman, 2009).

The treatment involved an acute phase of three to four weeks of intensive exposure and response prevention. Following this the nurses monitoring, restrictions and therapist sessions were gradually withdrawn. The patients' total stay in hospital was 9 and 12 weeks with a total of 25 and 20 therapist hours. Following this initial success, a further 15 patients were treated utilising a similar intensity and programme of treatment, which yielded successful or partially successful outcomes (Meyer, Levy, & Schnurer, 1974).

Following on from the work of Meyer (1966), Rachman and colleagues (1972) began developing methods to study compulsive urges in patients with OCD within a controlled laboratory setting. These studies were designed to develop their understanding of OCD and provide experimental support for the therapeutic work they had been undertaking (Hodgson & Rachman, 1976; Hodgson, Rachman, & Marks, 1972; Rachman & Hodgson, 1980). In the 1970s, Rachman and colleagues published their pioneering work on the spontaneous decay of compulsive urges (Hodgson & Rachman, 1972; Rachman et al., 1976). In a series of experimental procedures participants with OCD were exposed to situations which provoked anxiety and discomfort and a strong urge to carry out a compulsion (i.e. cleaning rituals (Hodgson & Rachman, 1972) and checking rituals (Roper, Rachman & Hodgson, 1973). It was found that after participants had carried out the compulsion, the urge and associated anxiety/ discomfort were significantly decreased (Rachman, De Silva, Roper, 1976; Hodgson & Rachman, 1972). Rachman and colleagues (1976) subsequently conducted further experiments where once again the urge to carry out a compulsion was provoked, but the patient was prevented from carrying out the ritual (Rachman et al., 1976). They found that the urges along with the associated anxiety and discomfort decreased over time, without the use of the ritual, a phenomenon termed 'spontaneous decay'. When patients were given such exposures repeatedly, it was found that the urge to complete the ritual peaked and then

progressively decreased over time, along with the anxiety and discomfort. The time taken for symptoms to dissipate after each exposure within the session became shorter over time (Likierman & Rachman, 1980). In 1979, the first RCT was conducted evaluating ERP and concluded that ERP with therapist modelling was moderately successful as an approach to the treatment of OCD (Rachman et al., 1979).

The observation of spontaneous decay in compulsive urges and anxiety represented a major breakthrough and provided the experimental underpinning for Exposure and Response Prevention (ERP) that is currently used in treatment. For example, an individual may be concerned that objects in their home are contaminated. Thus, therapy would involve exposure to these objects by touching and using them which would evoke feelings of anxiety and discomfort and the urge to engage in washing rituals. The individual would be supported not to engage in the urge to wash and would consequently have the opportunity to learn that their anxiety and discomfort will subside over time (provided they do not carry out any other safety seeking behaviours associated with the urge). Many studies have been conducted which support the efficacy of ERP (Foa & Kozak, 1996; Rachman & Hodgson, 1980). In 2003 the same spontaneous decay experiment (Rachman et al., 1976) was also utilised with covert compulsions (e.g. cognitive rituals) and the findings replicated (de Silva, Menzies, & Shafran, 2003). This was significant as it demonstrated that covert rituals could also be successfully treated with ERP.

In the late 1970s cognitive theories of psychological problems had emerged, most prominently by the work of Beck (1976) whose work had been inspired by the lack of progress in behavioural approaches to the treatment of depression. Beck proposed that "an individual's affect and behaviours are largely determined by the way in which he structures the world" (Beck, Rush, Shaw, & Emery, 1979, p. 3). Thus, cognitive therapy was developed to identify and test dysfunctional beliefs and cognitions (Beck et al., 1979). Salkovskis (1985) was influenced by the work of Beck (1976, 1979) and adopted cognitive concepts adapting and applying them to OCD in the first cognitive analysis of OCD (Salkovskis, 1985). The next section will therefore explore cognitive theories of OCD.

Cognitive Theory of OCD

Cognitive models of OCD fall into two broad categories with theories based on: 1) the hypothesis that OCD is caused by a dysfunction in general cognitive processing or 2) the hypothesis that certain kinds of dysfunctional beliefs underpin OCD.

Dysfunction in General Cognitive Processing.

The dysfunction in general cognitive processing model is based on findings that individuals with OCD, in comparison to those without, have been reported to do less well on neuropsychological measures of executive functioning and memory (Taylor et al., 2010). Such findings have led some theorists to propose that OCD is caused by abnormalities in information processing, potentially due to dysregulated neural circuitry (Taylor et al., 2010). The cognitive-structural model developed by Reed in 1985 postulates that OCD results from an individual's inability to structure and categorise their experiences and memories automatically. This failure results in compensation in the form of doubting, rumination and various compulsions and rituals. There are several limitations to this model. First, it fails to explain why an inability to structure information automatically leads to such distress and consequent behaviours, and why those are typically focused in a single domain. Second, deficits in neuropsychological tests are found in only a subset of individuals with OCD; and when they are identified they are often at a mild level. Similar results on neuropsychological tests are found across a number of other psychological disorders. Third, it is unclear as to whether poorer performance on neuropsychological tests is a cause or effect of OCD. Finally, the effectiveness of ERP treatment for OCD can also not be accounted for by this model (Taylor et al., 2010). The validity of the general cognitive dysfunction model in explaining OCD is negligible, and at best dysfunctional processing could be viewed as a nonspecific vulnerability factor (Taylor et al., 2010).

Cognitive Behavioural Theory of OCD.

The hypothesis that proposes that dysfunctional beliefs underpin obsessions and compulsions is explained by the cognitive-behavioural theory of OCD (Salkovskis 1985, 1989, 1996). This model builds upon Rachman and de Silva's (1978) observation that intrusive thoughts are a normal phenomenon which are experienced by around 90% of the general population (Rachman & de Silva, 1978; Salkovskis & Harrison, 1984). Based on the cognitive theory of emotional disorders (Beck, 1976), Salkovskis (1985) proposed that the difference between intrusive thoughts that are dismissed as meaningless by some individuals and those that develop into obsessions for others, is the appraisal attached to the thought. In OCD, intrusions are appraised as a threat linked to the harm of oneself or others, which is interpreted to be personally meaningful to the individual (Rachman, 1997; Salkovskis, 1985, 1997). It is this interpretation that mediates the distress that is caused (Barrera & Norton, 2011; Purdon, 2001). The cognitive hypothesis proposes, that if the intrusive thought (image or urge) is interpreted to mean that the individual may be or may become, responsible for

harm or its prevention then OCD will occur (Rachman, 1997, 1998; Salkovskis, 1985, 1989, 1997). Pertaining to the threat appraisal is the combination of how 'likely' and how 'awful' this occurrence might be, compounded by the individual's sense of how they might 'cope' or 'escape/ be rescued' from the circumstances (Salkovskis, 1997). The interpretation is followed by a series of reactions which can consequently strengthen the belief in the original interpretation and thus the appraisal can have both a causal and maintenance effect (Salkovskis, 1985).

As depicted in Figure 1. both the occurrence and content of the obsession can interact with background beliefs and earlier life experiences that have led to the individual's assumptions about the world e.g. 'it is better to be safe than sorry' or 'the world is a dangerous place, I can prevent harm' (Salkovskis, 2000). This can have the effect of making the interpretation feel more real or likely to the individual. Research has shown that obsessions are likely to be most distressing when the content on the obsession is in opposition to the individual's personal values or sense of self (Rowa, Purdon, Summerfeldt, & Antony, 2005). Once the interpretation has been activated the responses that the individual has to the interpretation of the *content* and *occurrence* of the intrusive through (image, impulse or doubt) serve to maintain the belief. There are four common maintaining responses as depicted in Figure 1 which illustrates this cycle, which has been termed the 'vicious flower' (Salkovskis, 1985, 1999). These responses form the petals of the 'vicious flower', and fall under the following categories; 1) Emotion/ mood changes, 2) Attention and reasoning biases, 3) Counter-productive strategies and 4) Neutralising. These factors interact with each other and consequently reinforce one another as well as increase the individual's sensitivity to triggers (Salkovskis, 1997). The use of such strategies is completely understandable as a means for the individual to try to rid themselves of the intrusion and prevent the occurrence of any harmful events connected with the thought (impulse, image, doubt) (Salkovskis, 1985). These actions which have the intention of preventing harm can be overt or covert, and include; compulsive behaviours, avoidance of situations associated with the intrusive thought, reassurance seeking (with the additional aim of diluting or sharing responsibility), as well as efforts to remove the obsessive thought from the individual's mind (Salkovskis, 1991; Salkovskis & McGuire, 2003). Salkovskis (1985) identifies two specific reasons that such behaviours are perpetuated and become excessive. First the use of compulsions is reinforced by the temporary reduction in distress and secondly, compulsions prevent the person from finding out how the world really works in that their appraisals are not disconfirmed.

In contrast to the cognitive deficit model the cognitive-behavioural model proposes that OCD is a "highly specific (problem) related to normal functioning rather than a function of some general deficit" (Salkovskis, 1996). Problems related to memory and decision-making difficulties are viewed as secondary to the emotional arousal and counterproductive strategies that the individual uses to cope with their symptoms (Salkovskis, 1996). The cognitive behavioural theory is widely accepted and utilised within clinical practice. This is the theory that is utilised to understand OCD within this thesis.

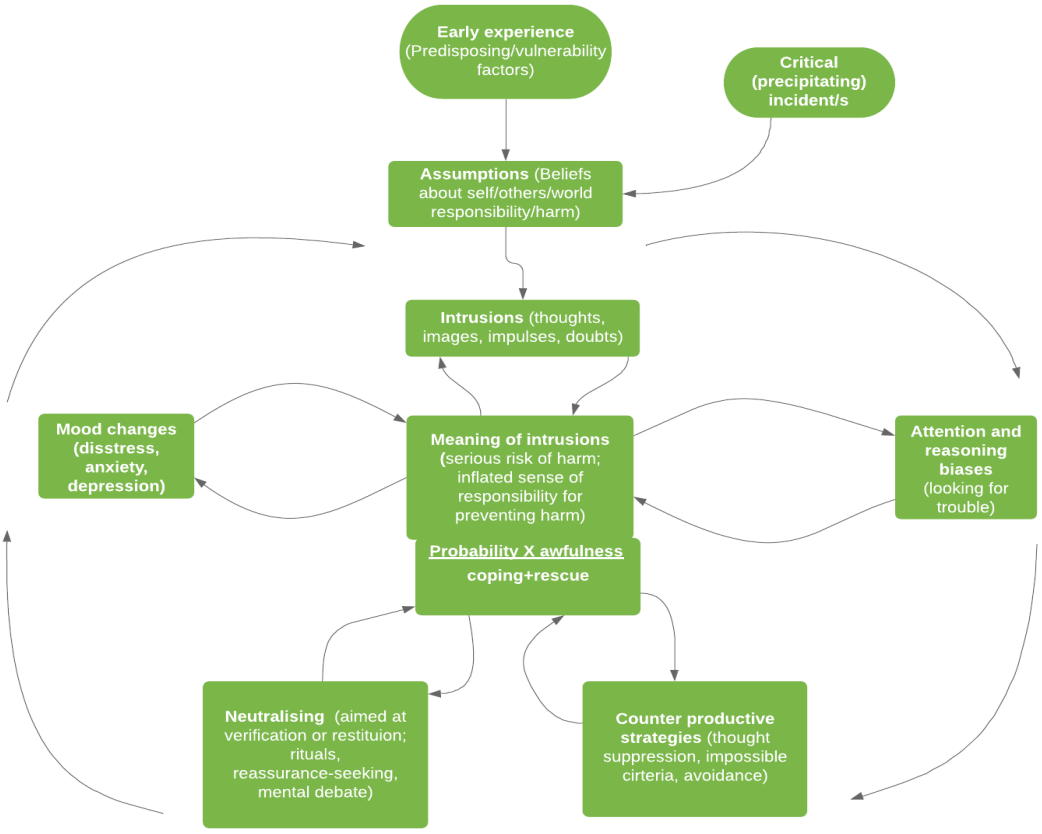

Figure 1. The cognitive-behavioural model of OCD: Interlocking vicious circles form the 'Vicious Flower'.

Cognitive Behavioural Therapy for OCD

CBT for OCD is an active, goal-oriented therapy in which the patient and therapist work together collaboratively to develop a shared understanding of how the individual's OCD is working, and to identify the maintaining factors. This initial process is called formulation and it is from this that the intervention stems (Kuyken, Padesky, & Dudley, 2011). A less threatening explanation for the problem is collaboratively developed (e.g. Theory A vs Theory B: an elaboration on the idea that OCD is a problem of worry rather than danger) and therapy then tests out this premise through a range of Behavioural

Experiments (BE) or exposure/ ERP tasks. CBT targets both cognitions and behaviours and therefore CBT has some overlap with ERP. CBT encourages the patient to undertake BE both in-session and for homework in-between sessions. The completion of homework is an important contributor to therapy success (Kazantzis et al., 2016; LeBeau, Davies, Culver, & Craske, 2013; Abramowitz, Franklin, Zoellner, & Dibernardo, 2002).

Efficacy of Cognitive and Behavioural Interventions

A substantial amount of research has been conducted to over the past 50 years which has evaluated both the efficacy and effectiveness of Behaviour Therapy in the form of ERP, Cognitive Therapy (CT) as well as Cognitive Behavioural Therapy (CBT) for OCD. ERP which is the predominant approach utilised in the USA has been shown to be an efficacious via several RCTs which have demonstrated its equivalence or superiority to pharmacological treatments (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Foa et al., 2005). ERP that is conducted *in-vivo* and is therapist-guided, accompanied by imaginal exposure to the individual's worst fears, has been found to be most effective, yielding the largest effect sizes (McKay et al., 2015; Abramowitz, 1996). Meta-analyses have shown that there is no significant difference between ERP and CT (Öst at al., 2015). CBT has been shown to be an effective treatment for OCD in a number of treatment studies and meta-analyses (Fisher & Wells, 2005; Olatunji, Davis, Powers, & Smits, 2013). The most recent meta-analysis showed that there is significant variability in how individual studies have reported treatment 'response', but what is clear is that there is a significant proportion of participants do not respond to CBT, approximately 38% (Öst et al., 2015).

Biological Theory

Several biologically based theories have been developed, however the phenomenology of OCD has not been a central focus to these theories, but rather they are underpinned by the assumption that OCD is a neuropsychiatric disease. Biological approaches have mainly focused on the serotonin neurotransmitter (Fineberg et al., 2006). This is due to the finding of Fernandez and Lopez-Ibor (1967), who discovered the effectiveness of clomipramine, a serotonin active tricyclic antidepressant, which was different to other tricyclics that did not impact on serotonin (Rapoport, Elkins, & Mikkelsen, 1980). It was found that for patients who received clomipramine their symptoms improved, although when it was stopped their symptoms worsened, regardless of the duration of which they had been taking the medication. When it was restarted their symptoms once again improved (Murphy et al., 1989). OCD responds to drugs that significantly inhibit the

reuptake of serotonin at the synapse. This led to the serotonin deficiency hypothesis which proposed that OCD was caused by a significant deficit in serotonin (Fineberg, Pampaloni, Pallanti, Ipser, & Stein, 2007). However, no unified theory regarding the role of serotonin in the aetiology of OCD has been accepted, and to date the mechanisms by which SSRIs provide their effects remains poorly understood (Fineberg et al., 2007). It is proposed that OCD that other neurotransmitters such as dopamine, noradrenaline and glutamate are involved which has led to the use of augmentation with atypical antipsychotics under the premise of the dopamine theory (Fineberg et al. 2006, 2010). This theory is based on abnormalities in the prefrontal region and in the basal ganglia (striatum, thalamus, amygdala) (Winslow & Insel, 1990; Harsányi, Csigó, Demeter, & Németh, 2007). It is suggested that the dysfunction in these areas occurs in the 'cortico-striato-thalamic' loop where dopamine is the dominant neurotransmitter and that this loop is linked to symptoms of OCD (Harsányi et al., 2007). It has also been suggested that obsessive-compulsive symptoms arise from informational processing abnormalities in these areas of the brain. Extensive research has been conducted in this area, however there are yet to be conclusive results regarding OCD (Swedo et al., 1992).

Efficacy of Pharmacological Interventions

Selective serotonin reuptake inhibitors (SSRIs) are the pharmacological treatment of choice for OCD. Response rates to SSRIs range from 35% to 47% as indicated by a $\geq$ 25% improvement from baseline on the Y-BOCS and a rating of 'Much *or* very much improved' on the Clinical Global Impression-Improvement scale (CGI-I) (Fineberg, Brown, Reghunandanan, & Pampaloni, 2012). Patient response to SSRIs has been found to be associated with improvement in quality of life. However, discontinuation of SSRIs results in relapse for approximately 52% of participants (Fineberg et al., 2007) and consequent loss of quality of quality of life (Hollander, Stein, Fineberg, Marteau, & Legault, 2010). The long-term use of SSRIs is required to maintain the treatment effect (Fineberg et al., 2012). A minimum of one to two years of continuation is recommended (Greist et al., 2003). Newer compounds targeting other neurotransmitter systems, such as glutamate, are undergoing evaluation (Fineberg et al., 2012).

Skapinakis and colleagues conducted the first network[7] meta-analysis for OCD in 2016. Results of this review reported that SSRI's are generally equally efficacious. No

[7] The method of network meta-analysis synthesises information from a network of trials which address the same research question but have investigated different interventions. This method allows for the combining of direct and indirect evidence into a single effect size. This enables all available treatments to be ranked in terms

evidence was found to suggest that one particular SSRI drug was more efficacious than another. The effect of medication compared with placebo was statistically significant, but the estimated mean difference was generally moderate. In previous literature it had been hypothesised that clomipramine may be more efficacious than SSRI's however no significant difference was found between SSRI's and clomipramine in the network meta-analysis (Skapinakis et al., 2016).

The network meta-analysis also reported that CBT, CT and ERP do not differ in their treatment effects for OCD. The three variations of these psychotherapies were found to be more likely to lead to a larger effect than medications. This finding is consistent with previous meta-analyses that also reported similar results in favour of psychotherapy in comparison to medication for OCD (Cuijpers et al., 2013). However, Skapinakis et al. (2016) raises an important limitation within the psychotherapy efficacy literature. The majority of psychotherapy trials (72%) have been undertaken with participants who are taking stable doses of antidepressants (the proportion of patients on antidepressant ranged from 13% to 100%). Thus, Skapinakis et al. (2016) state that these therapies cannot be considered as pure monotherapies. Skapinakis et al. (2016) conclude that psychotherapy is effective in patients who are taking antidepressant medications but remain symptomatic, and that the effect of psychotherapy as a monotherapy is unknown. It is proposed that further research is required to differentiate the effect of medication versus psychotherapy and also monotherapy versus combined therapy (Skapinakis et al., 2016)

Skapinakis et al. (2016) also suggest that the combination of psychotherapy and medications is possibly the most effective intervention and that this should be considered more widely particularly for patients with severe OCD. For patients who do not respond to SSRIs strategies including dose elevation or augmentation with antipsychotic medications are utilised. However, the long-term efficacy and tolerability of these strategies is yet to be fully determined (Fineberg et al., 2012). In 2013 Simpson and colleagues conducted the first RCT in adults with OCD comparing the effects of risperidone (antipsychotic medication) as an augmentation strategy with pill placebo. Participants had been taking an SRI for at least 12 weeks prior to the augmentation. The augmentation of risperidone was found to be not superior to placebo on any outcome measure (Simpson et al., 2013).

of efficacy, enabling the provision of estimates for interventions that have not been directly compared (Skapinakis et al., 2016).

Conclusion

In the past century, our understanding of OCD and its treatment has transformed. The experience of intrusive thoughts is accepted as a universal phenomenon experienced by all and it is the appraisal of these intrusive experiences that is key. It is clear that OCD is not uncommon, and its effects are pervasive and debilitating in the absence of appropriate treatment. We now have wide ranging evidence for psychological treatments specifically CBT (Öst et al., 2015). This represents an evolution from psychoanalytic therapy, through to reciprocal inhibition which was replaced by exposure theories leading to the development of cognitive behavioural treatments which are presently used today and inform the NICE guidelines. There is undeniable room for improvement of treatments to improve response rates with the ultimate aim of reducing the significant burden of OCD on the individual and economy.

Nonetheless, the treatments described started as pan-diagnostic and have become much more specific. In the process of development, we have carried forward various legacies, for example the use of hierarchies from behavioural therapy even though these are known to be no longer necessary (Abramowitz & Arch, 2014). We have also carried forward the format of therapy itself, which is typically delivered in weekly one-hour sessions. Rather like hierarchies the format of the one-hour weekly therapy session doesn't have an empirical basis but is rather tradition. Moving forward, there are two main evidence-based approaches to treatment. One is clearly underpinned by phenomenology and theory and the other is not. They lead to somewhat different conclusions about the treatment for individuals who have not responded to treatment. The next chapter will examine these approaches within the structure of the NICE guidelines and will challenge the tradition of the weekly format.

CHAPTER 3: LITERATURE REVIEW - PART TWO

The Status of Evidence-Based Treatment for OCD

Chapter Rationale

As established in Chapter 2, there are currently two evidence-based treatments for OCD; CBT and SSRI's. The aim of this chapter is to provide an understanding of and critical examination of the treatments currently being recommended and or used for OCD. This chapter continues as a narrative literature review and will achieve this aim by firstly examining the two evidence-based treatments within the framework provided by the NICE guidelines. It will also examine the different formats of treatment delivery that are recommended within this structure. The NICE guidelines were originally published in 2005 and although several evidence updates have been published, the NICE guidelines have not yet been fully updated or changed. This chapter will therefore include a critique of the guidelines with regards to relevant developments in the field since the inception of the NICE guidance for OCD.

Secondly the aim of this chapter is achieved by examining the treatments not currently supported by evidence, that despite the associated risks and lack of empirical support continue to be used. This is followed by an examination of how treatment response is currently defined. The clinical relevance and importance of this for patients who do not respond to treatment is discussed.

CHAPTER 3: LITERATURE REVIEW - PART TWO

The Status of Evidence-based Treatment for OCD

Provision of Care for OCD in the United Kingdom (UK)

Healthcare in the UK follows evidence-based guidelines provided by NICE utilising a 'stepped care' model. This model aims to provide a person-centred, step-by-step pathway to care utilising a standardised framework to guide provision of services. Stepped care should be implemented with consideration given to the individual needs, values and preferences (NICE, 2011). Referral to appropriate services is to be determined by the individuals' difficulties, allowing healthcare professionals to make strategic choices based on a patient's response to each treatment type (NICE, 2005). The aim is to improve access to optimal treatment and to identify the most effective, but least intrusive treatment option available for the individual within the context of their circumstances. Non-responders to initial treatments are assigned to increasingly intensive and expensive treatment types. Information about the patient's advocacy, their age and the severity of their symptoms should shape healthcare professionals decisions as they formulate a suitable route of care (NICE, 2011).

Crucially, the information and services delivered to patients should be in a format appropriate to the cultural, religious and functional capacity of the individual. In all treatment approaches, the importance of shared decision making is emphasised, ensuring individuals are provided with the right to make informed decisions about their care wherever possible (Department of Health, 2009).

Stepped Care Model Specific to OCD

For OCD NICE recommends psychological therapy in the form of CBT, medication (selective serotonin reuptake inhibitors (SSRIs)), or a combination of both interventions. CBT is recommended as an initial treatment option to be considered for all adults (NICE, 2005). NICE state that the format of treatment should be determined by the patient's OCD severity and its impact on the individual's quality of life.

The NICE six-step model for the treatment of OCD is depicted in Table 1. NICE guidance for OCD also incorporates guidance on the key priorities of care for body-dysmorphic disorder (BDD) (NICE, 2005). However, this review focuses exclusively on

OCD and will summarise the current recommendations for the assessment and treatment of adults with OCD.

Table 1.

The Stepped Care Framework for the Treatment of Adults with OCD

Who is responsible for care?	What is the focus?	What do they do?
Step 1 Individuals, public organisations, NHS	Awareness and recognition	Provide, seek and share information about OCD or its impact on individuals and families/carers
Step 2 GPs, practice nurses, health visitors, general health visitors, general health settings (including hospitals)	Recognition and assessment	Detect, educate, discuss treatment options, signpost to voluntary support organisations, provide support to individuals/ families/ carers/ work/ or refer to any of the appropriate levels.
Step 3 GPs, primary care team, primary care mental health workers, family support team	Management and initial treatment of OCD	Assess and review, discuss treatment options. According to level of impairment: Brief individual CBT with self-help materials, individual or group CBT, SSRI, or consider combined treatments; consider involving the family/carers in ERP.
Step 4 Multidisciplinary care in primary or secondary care	OCD with comorbidity or poor response to initial treatment	Asses and review discuss treatment options. CBT, SSRI, alternative SSRI or clomipramine, combined treatments.
Step 5 Multidisciplinary care with expertise in OCD	OCD with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse	Reassess, discuss treatment options. SSRI or dopamine, CBT or combination or SSRI or clomipramine and CBT. Consider care coordination, augmentation strategies, admission, social care.
Step 6 Intensive treatment or Inpatient care	OCD with risk to life, severe self-neglect or severe distress or disability	Reassess, discuss care options, care coordination. SSRI or clomipramine, CBT or combination or SSRI or clomipramine and CBT, augmentation strategies, consider admission or special living arrangements.

Step 1: Awareness and Recognition and Step 2: Recognition and Assessment.

Steps 1 and 2 of the NICE guidance pertains to the requirements of health professionals working with OCD, and the appropriate training and clinical supervision. Of note is the recommendation that each NHS Trust offering mental health services should have access to a specialist multidisciplinary team with knowledge of assessment and treatment options for OCD. It is recommended that this team should offer expert advice to healthcare professionals and should be responsible for conducting more specialised assessments, cognitive-behavioural and pharmacological therapy when needed (National Institute of Mental Health in England, 2004). Guidance relating to recognition of OCD symptoms and best practice in assessment and managing risk are outlined in this step.

Treatment options

Steps 3 to 6 outline the combination of treatments options and delivery formats for the treatment of OCD.

Step 3: Low-Intensity Interventions.

Typically, low-intensity CBT consists of 10-hours of therapist and patient contact-time, which is recommended as an initial approach for individuals with mild OCD. CBT may be delivered via the telephone, individual face-to-face appointments or group sessions, depending on the individual's preferences.

Updates of Importance Relevant to Step 3: Low-Intensity Interventions.

Since the inception of the NICE guidance for OCD, further research has been conducted which has implications for the provision of low-intensity interventions. The results of a well-controlled large RCT ($N = 473$), comparing two forms of low-intensity CBT (Computerised CBT (cCBT) Versus a guided self-help book focused on ERP) compared with therapist-led CBT (TAU) was published by Lovell et al. in 2017. This study aimed to determine if low-intensity treatment modalities could increase the accessibility of treatment for adults with OCD.

The findings of this RCT showed that at three, six and 12-months, neither cCBT nor guided self-help treatments had a clinically significant difference from the waitlist in any of the clinical outcomes measured. At 12-months, access to cCBT or guided self-help was found to be associated with a reduction in uptake of therapist-led CBT (Lovell et al., 2017). Further exploration of low-intensity interventions is warranted. However, these findings

challenge the efficacy of low-intensity treatments. The finding that self-help treatments are associated with a reduction in uptake of therapist-led CBT has implications for the NICE guideline and the stepped care model as will be further described below. The stepped care model recommends the progression of failure at Step 3 to Step 4. This signals that caution is warranted with regards to the delivery of such low-intensity interventions.

Step 4: CBT, SSRI or combined treatments.

For individuals who do not respond to low-intensity CBT, it is recommended that they are 'stepped up' and are offered the choice of a course of a SSRI or further CBT. In addition, patients who initially present with more moderate functional impairment should initially be offered more than 10-hours of CBT, or a course of an SSRI as a first treatment.

SSRI options in the UK include Fluoxetine, Fluvoxamine, Paroxetine, Sertraline or Citalopram. The guidelines state that if the patient experiences prolonged side-effects, the drug may be changed for another upon review. This step of the NICE guidelines also includes guidance on discontinuation or reduction of drug therapy, and maintenance doses. The tricyclic antidepressant, clomipramine, may be considered following an unsuccessful trial of an SSRI. The guidelines detail the risks associated with clomipramine and the medical precautions that should be adhered to with its use.

Step 5: CBT, SSRI or clomipramine, or combined treatments and consideration of augmentation strategies.

NICE advise that healthcare services should offer individuals with severe OCD a multi-modal combination of CBT with ERP and a course of an SSRI as standard initial treatment. For patients who are stepped up to this level pharmacological augmentation as well as social care interventions are recommended.

Updates of Importance Relevant to Step 5: Pharmacological augmentation strategies.

As described in Chapter 2, Simpson and colleagues (2013) compared the effects of two augmentation strategies with pill placebo. Participants had been taking an SRI for at least 12 weeks prior to the augmentation. The SRI was then augmented with either Risperidone (an antipsychotic medication) or ERP. The augmentation of risperidone was not superior to placebo on any outcome measure. Adding ERP was superior to both risperidone and pill placebo. The findings of this study suggest that pharmacological augmentation

strategies beyond what is recommended in Step 4 may have little clinical utility, which has implications for the guidance provided in Step 5.

Step 6: Intensive Treatments or Inpatient Care.

For a proportion of people with severe, chronic and "treatment-refractive" OCD, NICE recommend an intensive approach or inpatient care. It is recommended that this approach be considered for individuals who present with extreme distress or functional impairment, or in instances where there is severe self-neglect and an increased risk to life. Such individuals may have shown little or no-response to $\geq$ 2previous trials of independent or combined psychological and pharmacological treatments. CBT previously delivered in the standard format may have proven ineffective, and the duration insufficient. SSRI's or clomipramine or CBT or a combination all three plus pharmacological augmentation strategies are also recommended within this step.

Intensive Treatment.

The NICE (2005) guidance does not provide details with regards to what an intensive treatment should comprise. Time intensive treatments utilising CBT delivered either residentially or as an outpatient have been developed. The studies that have examined this approach have found intensive treatment to be effective and acceptable to service users (Abramowitz, Foa, & Franklin, 2003; Bevan et al., 2010; Emmelkamp, Van Linden Van den Heuvell, Ruphan, & Sanderman, 1989; Oldfield, Salkovskis, & Taylor, 2011; Storch, Gelfand, Geffken, & Goodman, 2003; Thornicroft, Colson, & Marks, 1991). However, there are considerable gaps in the literature, particularly in relation to identification of predictor variables for this method of treatment delivery and further empirical research is needed. Research has also not examined the acceptability of this format of treatment for the group of service users for whom it is recommended (i.e. those with the experience of $\geq$ 2 unsuccessful courses of treatment).

Although various models of intensive formats have been developed, in general, the criteria for an intensive treatment are (a) CBT delivered over a time period of no more than four weeks in length; and (b) a minimum of at least 10-hours of CBT, with at least five hours of CBT delivered within a single week. This is the definition that is adopted in the current thesis.

Discharge and managing relapse.

For individuals who have undertaken treatment within Step 6, NICE (2005) recommend that regular reviews should be arranged for 12-months after successful treatment by the mental health professional. The frequency of appointments should be determined and agreed by the health professional and patient.

In instances of patient relapse, a re-referral should be made by the individual's primary healthcare provider. It is suggested that this will allow the individual to bypass routine waiting lists and access further care as a matter of priority. If the service-user has maintained their gains, it is recommended that the patient is discharged from care after 12-months has elapsed. NICE (2005) guidelines do not specifically address relapse prevention or provide any specific directions for its implementation.

Future updates to the NICE guidelines.

Surveillance of the literature conducted in 2011 and 2013 proposed minor amendments to the NICE guidelines which are captured in the evidence updates (NICE, 2011, 2013). Moreover, the following areas are currently under review to address the limitations of the present recommendations raised by stakeholders (NICE, 2019):

- Advances in technologically enhanced CBT.
- The therapeutic use of Transcranial Magnetic Stimulation (rTMS) and Deep Brain Stimulation (DBS).
- Novel pharmacological interventions and augmentation strategies for treatment-refractory patients.
- Barriers to patients accessing NICE recommended treatments in line with their preferences.

While the NICE guidelines are developed in the UK they draw on the evidence of research conducted universally. However, there are other national guidelines available in other countries and it is important to be aware of these and the guidance they advise. Most comparable to the UK is the guidelines published by the APA. A brief examination of these guidelines in comparison to the NICE guidance is presented next.

Provision of Healthcare for OCD Outside of the UK

Similar to the UK stepped care model, the USA endorse a stage-by-stage provision of services. The APA guidelines for the treatment of OCD also recommend CBT and SSRI's as the first-line treatment for adults with OCD (APA, 2007). However, there are noticeable differences between the advised delivery of these treatments within the UK and the US (Table 1) In contrast to the standard 10-hours of CBT recommended by NICE (2005), APA (2007) advocate 13-20 sessions of weekly CBT for the average outpatient, with the duration of each session between one and two hours. This difference highlights a significant disparity in recommended 'dose' of treatment. Many of the treatment trials for which the efficacy of CBT has been determined have been conducted in the USA and have thus utilised a greater number of sessions (e.g. Foa et al., 2005). This raises the question of whether an optimal dose of therapy is being delivered to patients in the UK as a part of standard care. Busy clinical services may not always apply the NICE guidance as ideally specified (e.g. an episode of care is ended based on the patient's progress) but rather on a set number of predetermined sessions.

Distinct from the present NICE guidelines, APA (2007) highlights the application of technological resources in therapy. Computer-based CBT (cCBT) is provided as a format option for patients, with the addition of a touch-tone telephone with 24-hour access.

The APA also advises specific relapse prevention strategies including monthly booster CBT sessions, which are recommended for three to six months following successful ERP. Frequent booster sessions over a more extended period are suggested for patients for whom ERP has attained a partial remission of symptoms (APA, 2007). This recommendation also highlights a significant discrepancy between what is recommended in the UK with regards to follow-up. The NICE (2005) guidance only recommends follow-up be offered at the very final step of care (Step 6). Crucially it is not considered as a strategy for partial response earlier in the care pathway. This may indicate an important missing component of care, which requires further investigation.

The APA (2007) advise that if little to no improvement is achieved after the recommended 13 to 20 weeks of weekly CBT, then three weeks of daily CBT or 8 to 12 weeks of an SSRI treatment (with a reasonable trial of the highest dose) is recommended. Following this APA (2007) encourage the application of augmentation strategies such as the prescription of a different antipsychotic medication, combined SSRI and CBT treatment, or a further intensity increase of ERP daily sessions. The APA (2007) considers a total of 50

hours of CBT delivered either weekly or daily, to be an adequate trial of CBT for those who have not initially responded. After this, alternative treatment approaches may be attempted. If is suggested that if an even more intensive treatment is required, a hospital setting may be recommended especially for those with medical conditions or where there is a risk of suicide.

In summary, APA (2007) provides much more specific and directive recommendations for the provision of intensively delivered treatments in comparison to NICE. Nonetheless, the guidelines provided by NICE and APA are specific in their treatment recommendations with regards to evidence-based treatments. However, the treatments that are recommended are not necessarily those that are practised, and a variety of alternative non-evidence-based treatments are available. These alternative treatments are often sought and utilised, by those who have not responded to previous evidence-based treatment. As outlined in Chapter 2 when individuals do not respond to treatment, they often remain significantly impaired by their symptoms. The desperation of those severely affected by OCD is demonstrated by their pursuit of treatments that are inconsistent with national guidance, particularly those that carry substantial risks. These treatments will be outlined in the following section.

Table 1. Comparison of NICE and APA treatment recommendations for OCD

Level of Intervention	Intervention and number of hours recommended per intervention	
	NICE	**APA**
Initial intervention: Low Intensity	Up to 10 hours of CBT delivered via: - telephone - individual face-to-face or - group sessions (depending on the individual's preferences)	-Computer-based CBT (cCBT) with a touch-tone telephone with 24-hour access -Or SSRI
If low intensity is unsuccessful patients are stepped up to receive:	-A minimum of 10-hours of CBT therapist and patient contact-time -And/ Or a SSRI	-13-20 sessions of weekly CBT: Session duration 1 to 2 hours per session -And/Or an SSRI
Further step is to receive:	-Further CBT (no recommendation re hours) - SSRI multi-modal with pharmacological augmentation	-3 weeks of daily CBT or -8 to 12 weeks of an SSRI treatment at a high dose
Further step is to receive:		-Augmentation of antipsychotic medication, combined SSRI and CBT treatment, -Further intensity increase of ERP daily sessions. Approx. 50 hours of CBT
Final level of intervention	If little or no-response to $\geq$ 2 previous trials of independent or combined psychological and pharmacological treatments: Step 6: inpatient or specialist intensive treatment are recommended.	Alternative treatment approaches may be attempted. -More intensive treatment is -hospital setting recommended for those with medical conditions/ risk of suicide
Relapse Prevention following treatment	-Follow-up is only recommended for those who have received the final step of care (Step 6) which is or intensive or inpatient care. -Follow up for 12 months	- Monthly booster CBT sessions, for 3 to 6 months following successful ERP. - Frequent booster sessions over a more extended period are suggested for patients for whom ERP has attained a partial remission of symptoms

Non-Evidenced-Based Treatments of OCD

There are two main psychological treatments that are not recommended for OCD but continue to be utilised and several neurological interventions that are also available.

Non-Evidence-Based Psychological Therapies for OCD

Acceptance and Commitment Therapy (ACT).

Acceptance and Commitment Therapy (ACT) is classified as a 'third-wave' psychotherapy underpinned by Relational Frame Theory (RFT) (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In general, the model assumes that anxiety can be diffused using cognitive techniques by becoming mindful to one's emotional experience (Hayes, 2004). Öst and colleagues (2014) conducted a comprehensive meta-analysis of ACT for psychiatric disorders reviewing 60 studies which included over 4000 participants with clinical diagnoses including OCD. Öst et al. (2014) found that there was little evidence to suggest ACT is comparable to other psychological treatment options for treating any disorder. Diagnostic criteria in the included OCD studies were vague, and the one controlled study which did find an effect, compared ACT with a treatment which is not currently established as an evidence-based treatment for OCD. To that end, NICE (2005) explicitly advises that healthcare professionals should discourage patients from seeking alternative therapies by highlighting the lack of evidence for their clinical efficacy.

Psychodynamic therapy.

The theoretical foundations of Freud have been revised to incorporate more contemporary psychodynamic perspectives, which include an interpersonal psychodynamic understanding of OCD (O'Connor, 2008). It is postulated that in the treatment of OCD, it is necessary to identify and alter the defence patterns that perpetuate OCD (Salzman, 1997). Psychodynamic approaches are not a treatment of choice for OCD due to the ineffectiveness of this therapy and non-evidence-based approach to treatment (Insel, 1984). There is an absence of evidence examining this approach, and the little research that has been conducted has not demonstrated efficacy (Esman, 2001). Most individuals who have had either psychoanalytic or psychodynamic therapy for OCD do not report significant reductions in their symptoms (Pigott, Myers and Williams, 1996). However, it should be noted that the reduction of symptoms may not be the central objective of therapists who employ such approaches (Gabbard, 2001).

Neuropsychological Interventions for OCD

Electroconvulsive therapy (ECT).

The use of electroconvulsive therapy (ECT) is not recommended for OCD by NICE (2005). The process of ECT involves directing an electrical current into the brain, eliciting a seizure. Liu and colleagues (2014) suggest the use of ECT for OCD and comorbid depression when first-line treatments have failed. However, ECT has been shown to have little benefit for improving OCD symptoms, causing no change and even worsening symptoms for all participants despite reducing co-morbid symptoms of depression and anxiety (Lins-Martins, Yucel, Tovar-Moll, Rodrigues, & Fontenelle, 2015). A systematic review conducted by Fontenelle et al. (2015) concluded that the efficacy of ECT is not clear, as the characteristics of respondent cases versus non-responder are often not comparable. They emphasised the absence of RCTs, illustrating the need for further empirical investigation into the applicability of ECT as a potential for treatment resistant OCD.

Psychosurgery.

Neurosurgery is not recommended for OCD, and its use is controversial (APA, 2007). NICE (2005) state that all attempts should have been made to engage patients with CBT and all pharmacological options explored with the addition of intensive and inpatient treatments utilised before psychosurgery is considered as a therapeutic method for OCD. NICE (2005) advises that professionals considering these options should refer to criteria produced by Matthews and Eljamel (2003) when deciding the suitability of any neurosurgical treatment for patients with “intractable” OCD.

There are four main ablative procedures being used for OCD these include; 1) anterior subcaudate tractotomy (ACING), 2) anterior capslotomy (ACAPS), 3) cingulotomy and 4) limbic leucotomy (Anderson & Ahmed, 2003; see Bejerot, 2003 for a description of each procedure). While each of these procedures differ in method, they all involve inducing irreversible lesions into specific areas of the brain (Brown et al., 2016). Matthews and Eljamel (2003) review the empirical studies of ACING and ACAPS and discuss the therapeutic use and adverse effects. Considerable risks are associated, and side effects in general include cognitive impairment and personality changes. Side effects of ACAPS included apathy and poor judgement. The experience of epileptic seizures, urinary incontinence and memory difficulties have been reported following limbic leucotomy procedure which combines ACING with orbitomedial cortex legions (Matthews & Eljamel, 2003).

A study of patients who received ACING between 1989 and 1995 found that only 25 - 30% were significantly improved as a result of this procedure at a mean follow-up duration of 26.8 months (Baer, Rauch, & Ballantine, 1995). The results were somewhat improved for the procedure of subcaudate tractotomy with 50% reporting a satisfactory response. The highest reported satisfactory response rates have been for ACAPS and limbic leucotomy which were 67% and 61% respectively (Anderson & Ahmed, 2003). The authors acknowledge, however, that sample sizes in such studies are small, restricting the extent to which clear conclusions can be drawn regarding the effectiveness of these procedures (Matthews & Eljamel, 2003). It is reported that patients who do not respond to the above-mentioned procedures, often undergo further repeated surgeries to expand the size of the lesion in hope of improved outcomes (Anderson & Ahmed, 2003).

Deep Brain Stimulation (DBS).

In terms of non-ablative procedures deep brain stimulation (DBS) involves the insertion of electrodes which stimulate regions of the brain. If DBS is found to have an unsatisfactory response it is reversible (Luyten, Hendrickx, Raymaekers, Gabriels, & Nuttin, 2016). Amelioration of symptoms is reported to range from 56% - 75% in some studies (Nuttin, Cosyns, Demeulemeester, Gybels, & Meyerson, 1999; Denys et al., 2010). However, side effects include mild memory problems, and the report of adverse events during follow-up include epileptic seizures, suicide attempts and intracerebral haemorrhages (Luyten et al., 2016). It is unclear whether these events can be directly attributed to the procedure, but it suggests that this approach is not without risk.

Repetitive Transcranial Magnetic Stimulation (rTMS).

Repetitive transcranial magnetic stimulation (rTMS) is less invasive than DBS. The process involves the external delivery of repeated electrical stimulation to a discrete brain region, which does not require the patient to undergo surgery. Systematic reviews of the efficacy of rTMS for treating OCD, have resulted in conflicting conclusions. Mishra et al. (2011) highlighted the limited number of placebo-controlled studies for OCD, leading the authors to deduce that rTMS is insufficient for OCD. However, methodological advancements appear to have been made in more recent years with a meta-analysis indicating the short-term effect of rTMS to be superior to placebo (Zhou, Wang, Wang, Li & Kuang's, 2017). The authors were able to identify the specific areas of the brain which evoked the highest level of positive response. Further replication of RCTs are required to examine the

long-term therapeutic effects and this approach should be compared with active treatment controls.

In summary, if the first episode of treatment for OCD is unsuccessful, there are a range of treatments that can be potentially received. Some of these are evidence-based and carry no or minimal risk and side effects while for other treatments the evidence is inconclusive or scant and significant risks and side effects are associated. The progression of treatment recommendations is based on the individual's demonstrated 'response' to a specific treatment. Thus, how treatment response is defined is crucial. The next section will therefore outline the current definitions of treatment response.

Defining Treatment Response

The terms 'response', 'remission' and 'recovery' have seemingly been used interchangeably across the OCD literature. Inconsistencies in how OCD severity is distinguished, poses an obstacle for the accurate interpretation of clinical outcomes and limits the capacity for comparison of therapeutic modalities (Mataix-Cols et al., 2016). The development of standardised definitions is essential to supporting comparisons across studies and involves mapping the connection between conceptual definitions and how they manifest in a clinically measurable way. This is also of paramount importance in the use of standardised treatment recommendations (e.g. NICE).

Mataix-Cols and colleagues (2016) aimed to construct universal definitions of the term's 'response', 'remission', 'recovery' and 'relapse' via expert consensus. Experts were able to reach a consensus on the characteristics of patient' response', 'remission', 'recovery' and 'relapse', for which they were in > 95% agreement for conceptual explanations of the terms. However, reaching congruent operational definitions proved more difficult, with <18% of the experts in agreement (Mataix-Cols et al., 2016). Nonetheless, the finalised classifications offer clear guidance, as outlined below.

Treatment Response

The experts agreed that treatment response should be conceptually defined by a reduction in symptoms, compared to baseline severity, which is clinically significant in terms of the symptom duration, distress and impact on functioning for the individual. Such response should have been apparent for at least one week, as evidenced by a reduced Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score of $\geq$ 35% from pre-treatment. In addition, a Clinical Global Impression-Improvement (CGI-I) rating of 1 ("very much

improved") or 2 ("much improved") is required. Partial response is defined in the same way, with a percentage reduction in Y-BOCS scores $\geq$ 25% but $\leq$ 35%, in combination with a CGI-I rating of at least 3 ("minimally improved") (Mataix-Cols et al., 2016).

Remission

Conceptually, patients are defined to be in remission when symptoms are minimal and do not meet clinical diagnostic criteria or interrupt the patient's daily functioning. Remission is indicated by a Y-BOCS score of $\leq$ 12 in addition to a Clinical Global Impression-Severity (CGI-S) rating of 1 ("normal, not at all ill") or 2 ("borderline mentally ill"). Again, this effect should be present for a minimum of one week or more (Mataix-Cols et al., 2016).

Recovery

The conceptual definition of recovery is similar to remission in that the patient's symptoms should not meet diagnostic criteria. OCD symptoms may fluctuate, but should not impede the individual's functioning, and further therapy is not warranted. It is at this stage that it is suggested that clinicians should review whether treatment discontinuation and/ or relapse prevention is appropriate. Experts agreed that recovery is characterised by these gains being sustained for at least one year (Mataix-Cols et al., 2016).

Regarding how recovery is operationalised, Burchi, Hollander, & Pallanti (2018) argue that current definitions (as outlined in the expert consensus) are insufficient as RCTs provide figures of 'response' rather than of 'remission', which typically indicates a severity reduction of 25-35%, as measured by the Y-BOCS. These figures may give the impression of symptom improvement, but the disorder may remain incapacitating for the individual as the decrease is relative to their pre-treatment score. In the same vein, different rates of 'recovery' are determined when the parameters for response are changed. As such, these authors assert that several factors be considered when defining recovery from OCD, in order to capture a more representative view of the severity of the disorder. They propose that recovery should be distinguished by a combination of symptomatic, duration, and functional criteria.

Given that the mean duration of many RCTs in OCD is 12-weeks, and that 32 -70% of participants achieve remission over this period, Burchi et al. (2018) propose that 12-weeks of symptom reduction should be the time point at which 'remission' should be judged. Based on literature from other disorders (e.g. Schizophrenia), it is suggested that gains should be maintained for at least two years to be classified as 'recovered'. Burchi and colleagues

(2018) also recommend the use of subjective measures of participant's functioning which are distinct from their OCD symptoms. It is argued that the CGI-S and CGI-I do not reflect subjective improvement. Thus, the incorporation of scales such as the Work and Social Adjustment Scale (WSAS) (for which a score of <10 is ideal) are suggested in order to provide a more comprehensive overview of participants' progress (Burchi et al., 2018).

Relapse

Relapse is characterised by the return of symptoms following the previous achievement of response, remission, or recovery (Mataix-Cols et al., 2016). That is, the individual's symptoms meet the clinical criteria for a diagnosis of OCD and their obsessions, compulsions and avoidance present impairment to functioning and increased distress. Operationally, individual's previous treatment response will now fail to show a Y-BOCS reduction of ≥ 35% from their pre-treatment score, and they will have a CGI-I rating of at least 6 ("much worse") for one month or more (Mataix-Cols et al., 2016).

Understanding Treatment Non-Response from a Psychological Perspective

To date several studies have examined the causes of participants' non-optimal response to treatment. Symptom severity has been identified as a predictor of poor response to treatment (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002) whilst older research suggests that severe concurrent depression and overvalued ideation (i.e. the strong belief that fears are realistic and that consequent behaviours prevent actual disasters) may be important (Foa, 1979). Few studies have incorporated cognitive measures into their research designs and therefore more research with regard to how cognitive factors affect treatment response is needed (Keeley, Storch, Merlo, & Geffken, 2008). One of the key theories utilised to conceptualise non-treatment response is that developed by Rachman in 1983. Rachman (1983) proposed that individuals may fail to respond to treatment as a result of either 'technical treatment failures' or 'serious treatment failures'. A 'technical treatment failure' is when a treatment is fundamentally inadequate or the therapist does not adequately deliver the treatment (Rachman, 1983). A 'serious treatment failure' is when the treatment is adequate and delivered adequately, but the patient shows minimal improvement (Rachman, 1983). The ways in which these two types of 'treatment failures' are addressed is different. However, the proportion of 'treatment resistant' or 'treatment refractory' OCD treatment failures is not well established (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). Research conducted at a specialist treatment centre in the UK (Centre for Anxiety Disorders and Trauma) (CADAT), reported that only

a minority of patients defined by referring services as 'treatment refractory' had received adequate treatment (Stobie et al., 2007). This raises the concern that a proportion of people with severe and disabling OCD are not offered treatment that provides a valid chance of helping them (Stobie et al., 2007).

At a practical level, the implications for participants being identified as 'treatment resistant' or 'refractory' can be profound. Patients who do not respond optimally to treatment have increased socio-occupational dysfunction, increased health care costs, inpatient admissions and an elevated suicide risk (Hollander et al., 1996). Individuals are sometimes left thinking that nothing can be done to help them. This in turn can cause further pathology particularly in the form of depression (Masellis, Rector, & Richter, 2003) and lead individuals to seek forms of treatment that may have little empirical support and involve significant risks, such as psychosurgery as previously discussed (Matthews & Eljamel, 2003). Such implications also have obvious economic consequences. The use of labels such as 'treatment refractory' needs to be questioned from both a moral perspective and one that examines the utility of such terms. Such labelling could be viewed as verging on an abuse of the power imbalance that exists between health professional and the patient. It can be argued that rather than using a label that insinuates that no further improvement is likely, we as science-practitioners (involved in the provision of treatment for OCD) hold the responsibility to examine more closely the factors that are involved in treatment non-response and understand how they can be overcome in order to improve available treatments.

Conclusion

This chapter has reviewed the available treatments for OCD in terms of those that are evidence-based, looking closely at the options available for those who do not respond to treatment. Within the final step of the NICE guidance (Step 6) the options are administration of larger doses of medication or augmentation or psychological therapy (in which we need to find ways of delivering therapy that increases its impact). Considering the concerning evidence reported by Simpson et al. (2013) regarding augmentation with antipsychotic medication, the treatment option that stands out is that of intensive treatment. Intensive CBT is not a different treatment but rather a different format of delivery. This raises the issue of mode of delivery. There are good reasons to move away from the model of one therapy hour per week. These reasons include the issues of momentum and continuity and opportunities for increased in-session experiential learning. This has been reflected in the NICE guidelines for more severe cases, but without a great deal of empirical evidence. The investigation of intensive formats examining their acceptability from the perspectives of both the service user

and therapists' is warranted and will thus constitute a focus of this thesis. The evidence underpinning the NICE guideline recommendation will be systematically evaluated and effort will be given to examining the factors of treatment non response from the perspective of the service user.

CHAPTER 4: STUDY 1

Is Intensive Cognitive Behavioural Therapy an Efficacious and Acceptable Treatment Format for Adults with Obsessive Compulsive Disorder? A Systematic Review of Randomised Controlled Trials

Chapter Rationale

As discussed in Chapters 2 and 3 of this thesis, the NICE guidelines recommend an intensive version of CBT for OCD in Step 6 of the stepped care framework. In line with the third objective of this thesis, which is to evaluate the evidence-base for this recommendation, this chapter presents a systematic review of the evidence for the efficacy of intensive CBT for OCD. It is well established that Randomised Controlled Trials (RCTs) encompass the precision required for providing the best evidence for the efficacy of interventions (Petticrew & Roberts, 2006). For this reason, RCTs were the research design of the studies that were sought to be included in this review.

This declaration concerns the article entitled:			
Is Intensive Cognitive Behavioural Therapy an Efficacious and Acceptable Treatment Format for Adults with Obsessive Compulsive Disorder? A Systematic Review of Randomised Controlled Trials.			
Publication status (tick one) **Draft manuscript** [x] **Submitted** [ ] **In review** [ ] **Accepted** [ ] **Published** [ ]			
Publication details (reference)	Millar, J.F.A., Bauer, A., Halligan, S. L., Purnell, SA. & Salkovskis, P.M.		
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Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.		
Signed		**Date**	27.09.2019

Is Intensive Cognitive Behavioural Therapy an Efficacious and Acceptable Treatment Format for Adults with Obsessive Compulsive Disorder? A Systematic Review of Randomised Controlled Trials

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Abstract

Background: Clinical guidelines recommend an intensive version of Cognitive Behavioural Therapy (iCBT) be made available to individuals with Obsessive Compulsive Disorder (OCD) who have previously received evidence-based treatment and have not responded. However, the evidence underpinning this recommendation has not been systematically reviewed to determine the acceptability and efficacy of this approach for this group of service users. In this systematic review we aimed to 1) assess the efficacy of iCBT for adults with OCD, and 2) assess the acceptability of iCBT for adults with OCD.

Methods: This review was preregistered on PROSPERO: CRD42018106840. We searched the electronic databases of; the Cochrane Controlled Register of Trials (CENTRAL), Cochrane Library, PubMed, Embase and PsycINFO for articles published between 1966 and November 2018. We also searched reference lists and other sources for registered or ongoing studies.

We included Randomised Controlled Trials (RCTs) of adults with OCD (according to DSM or ICD), comparing iCBT to active or non-active controls. iCBT was defined as; at least five hours of CBT delivered per week, over a time period of no more than four weeks, with a minimum total number of 10 CBT hours. The primary outcome was difference in change in OCD symptoms from baseline to follow-up utilising a continuous measure of OCD symptoms (e.g. Y-BOCS). Secondary outcome was difference in attrition rates between arms. Each study was assessed for risk of bias using the Cochrane tool.

Results: Searches retrieved 5125 records. After screening we included four RCTs ($N = 313$). Each study individually demonstrated large effect sizes in favour of iCBT compared to their respective control, and there was a low mean drop-out rate across studies. However, none of the included studies focused on participants with a specific history of treatment failure. Studies were highly heterogeneous, which precluded meta-analysis.

Conclusions: The effect of iCBT on OCD symptoms appears to have evidence of promise for efficacy, and iCBT appears to be acceptable. Further high quality RCTs are required to demonstrate the efficacy and acceptability of iCBT for OCD, particularly focusing on treatment non-responders who are the focus of the NICE guidelines.

Key Words: Obsessive Compulsive Disorder, OCD, Intensive Cognitive Behavioural Therapy, iCBT, CBT, Randomised Controlled Trial, RCT.

Background

Obsessive Compulsive Disorder (OCD) is defined by the presence of obsessions (i.e. recurrent and persistent thoughts, images or urges that are intrusive, unwanted and cause significant distress or anxiety) and compulsions (i.e. repetitive behaviours or mental acts that are carried out in response to obsessions) (APA, 2013). OCD has a life time prevalence of approximately 1 to 3% (Kessler et al., 2005; Ruscio et al., 2010; Torres et al., 2006). In the absence of appropriate treatment its course is chronic, leading to significant costs for the individual sufferer in terms of significant life impairment and disability (Asnaani et al., 2017; Huppert et al., 2009; Sahoo et al., 2017), as well as significant economic costs (DuPont et al., 1995; Hollander et al., 1997). The World Health Organisation (WHO) includes OCD within the category of disorders ranked sixth globally for largest contributors to "non-fatal health loss" (WHO, 2017).

OCD has moved from a poorly understood and poorly treated disorder to one that can be successfully treated with Cognitive Behavioural Therapy (CBT) which includes Exposure and Response Prevention (ERP)[8] (Öst et al., 2015). Despite the substantial developments in efficacious treatments, a proportion of those affected by OCD (approximately 38%) do not respond to treatment (Öst et al., 2015) and remain severely disabled by their symptoms. Standard CBT generally employs a weekly format delivered over an extended period of weeks (e.g. 12 - 20) (APA, 2013).

CBT for OCD is underpinned by behavioural theory, which posits that compulsive behaviours are essentially a form of learned avoidance of a feared stimulus (obsessions). In this framework, ERP supports the extinction of compulsions through a combination of *exposure* coupled with elimination of avoidant coping behaviours (Rachman, 1971). Building on this, cognitive behavioural theory further highlights the important of *interpretations* that an individual makes about the occurrence or content of obsessional thoughts that mediate the distress they cause. Specifically, intrusive thoughts (obsessions) are interpreted as personally meaningful and threatening, for example meaning that the individual could be responsible for harm and its prevention (Salkovskis, 1985, 1997, Rachman, 1997). Contemporary CBT aims to address problematic appraisals as well as decouple links between obsessions and compulsions that are at the core of OCD.

[8] Cognitive Therapy (CT) (including elements of exposure) and Exposure and Response Prevention (ERP) (a form of behaviour therapy) do not differ significantly in clinical outcome (Öst et al., 2015). Thus, for the purposes of this review they will be referred to synonymously as CBT and for the intensive format as iCBT.

More recently Craske et al. (2008, 2014) and others (Abramowitz & Arch, 2014) have drawn on the formulation of inhibitory learning theory (based on principles of extinction learning and memory) to make specific recommendations for optimising CBT's effectiveness. It is suggested that CBT should be delivered in-sessions that are close in proximity and include multiple situations. This will enable the development of new non-threatening associations to be made between stimuli in an individual's memory, and will enhance how easily these new associations can be accessed and retrieved (Weisman & Rodebaugh, 2018). It is proposed that *intensive* formats meet this need, as sessions occur closer together and are longer, allowing time within sessions for CBT to take place in multiple settings. Consistent with this, it has been proposed that in treating OCD, *intensive CBT* (iCBT) formats may be more effective for those with severe difficulties for whom standard treatment has failed (Foa & Steketee, 1987). This proposition is supported by UK guidelines for the treatment of OCD which recommend that an intensive version of treatment be made available to those who have undertaken at least two courses of CBT, augmented with pharmacological interventions (NICE, 2005, 2018).

Although several systematic reviews and meta-analyses have examined and demonstrated the efficacy of CBT for OCD (Abramowitz, 1997; Olatunji, Davis, Powers, & Smits, 2013; Öst et al., 2015; Rosa-Alcázar, Sánchez-Meca, Gómez-Conesa, & Marín-Martínez, 2008) only one review has specifically considered the efficacy of iCBT. Jónsson, Kristensen, and Arendt (2015) aimed to evaluate the effectiveness of iCBT for both youth and adults, as delivered in only outpatient (versus inpatient) settings. They were inclusive of all study designs, and the resultant studies were heterogeneous across participants, interventions and comparators, as well as the outcome measures used. A risk of bias tool was included, but the findings of this were not reported in detail. Examination of the subset of OCD patients with a history of treatment failure for whom the NICE guidance is in place was not reported.

With these considerations in mind, the present systematic review included only studies employing a RCT design, and included studies conducted in inpatient settings (where iCBT is often utilised in practice) as well as outpatient settings. We asked the following questions; 1) What is the efficacy of iCBT for OCD for adults delivered in either outpatient or inpatient settings compared to weekly CBT or other comparator; and 2) Is iCBT acceptable to adults with OCD when delivered in either outpatient or inpatient settings? Efficacy was indicated by difference in change from baseline to follow-up between intervention and control arms, whereas acceptability was evidenced by participant drop-out rates. We focused on dropouts versus participants who declined to take part or withdrew

following randomisation, as "declining participation" may reflect the acceptability of randomisation rather than treatment acceptability (Öst et al., 2015).

Method

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed in reporting this review (Liberati et al., 2009). A protocol for the review was registered via the International Prospective Register Of Systematic Reviews (PROSPERO) (registration number: CRD42018106840). We followed the guidance outlined in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011).

Study inclusion criteria

Study Design.

Parallel design RCTs were eligible for inclusion. We included studies if they were published or submitted for publication in a peer review journal, submitted as a part of a doctoral theses in English, or were presented at a conference (conference abstracts were included if full details of the study could be obtained from the authors).

Participants.

Participants were adults of $\geq$ 18 years with a diagnosis of OCD according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) (APA, 2013), International Classification of Diseases, 10th revision (ICD 10) (WHO, 1992) or other internationally accepted diagnostic criteria (e.g. DSM-IV, DSM-III-R). We applied no restrictions on gender, ethnicity or use of medication. We did not exclude studies because of comorbidity, provided that the primary intervention was aimed at OCD.

Setting.

We applied no restrictions on the basis of setting in which the treatment was delivered (i.e. intensive vs outpatient).

Interventions.

The same criteria that Jónsson et al. (2015) used in their systematic review are applied here. Thus, iCBT was included that met the following criteria:

1. The CBT was delivered over a time period of no more than four weeks in length
2. A minimum total of 10 hours of CBT was delivered
3. At least five hours of CBT was delivered per week

4. The CBT was delivered by one or more therapists

Comparators.

We accepted any comparator conditions, including:

1. Weekly delivered CBT
2. Treatment as usual
3. Wait list control
4. Other active psychotherapy intervention
5. Pharmacological interventions

Outcome.

Primary Outcome: Change in OCD Symptoms.

We examined OCD symptoms from pre-to-post treatment, measured using standardised scales, e.g. the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989).

Secondary Outcome: Acceptability.

We measured acceptability as the difference in proportion of dropouts between trial arms. We adopted the dose-response criteria for defining attrition (Roseborough, McLeod & Wright, 2016), where dropouts are defined as participants who attended at least the first session of treatment but stopped attending before the end of the treatment period specified for the study.

Search Methods for Identification of Studies

Electronic searches.

An electronic literature search was undertaken utilising the Cochrane Controlled Register of Trials (CENTRAL) and the Cochrane Library. In addition, the databases of PubMed, EMBASE and PsycINFO were searched for articles published between 1966 (when Meyer (1966) first published on Exposure work for OCD) and November 2018.

We used Medical Subject Headings (MeSH) or equivalent terms. The expertise of an information specialist was sought to ensure differences between databases with respect to search terms and indexing were identified. Searches were tailored to each database. We did not include words referring to the format of the intervention (i.e., intensive) due to the narrowing effect of this on the search and decreased comprehensiveness.

We searched databases using terms related to: “obsessive-compulsive disorder”, “cognitive behavioural therapy” and “randomized controlled trial”. An example of the full search strategy is available in the Appendix A.

Other searches.

Unpublished trials were searched for via the Economic and Social Research Council (ESRC), the National Research Register (NRR), WHO international Clinical Trials Registry Platform and ClinicalTrials.gov. The website theses.com was used to search for PhD theses conducted in the UK and Ireland. We searched reference lists of previous relevant systematic reviews, (Jónsson et al., 2015; McKay et al., 2015; Öst et al., 2015) and reference lists of all included studies for further relevant studies. We contacted authors of included trials seeking their knowledge of any unpublished or ongoing trials.

Data Collection and Analysis

Selection of studies.

Title and abstract screening were conducted by two independent screeners (JM and AB/ SAP) using Covidence. When abstracts were not available electronically, or if insufficient information was included in the abstract to assess inclusion criteria, the full article was sought.

The full-text articles were independently screened by two reviewers (JM and AB) using the inclusion criteria. Where full text articles were not available via interlibrary loan the authors were contacted directly. Reasons for exclusions of ineligible studies were recorded (Table 2). Any conflicts were discussed between the two reviewers until a consensus was achieved, in consultation with a third party when necessary. The selection process was recorded via a PRISMA flow chart (Figure 1) (Moher, Liberati, Tetzlaff, Altman, & Group, 2009).

Data Extraction and Management

Two reviewers (JM & SAP) independently extracted data from the included studies, and a third reviewer (AB) checked over the extracted data. The following information was extracted from each study:

Method. Study design, publication date, country conducted, single or multi-site, duration of study, setting (outpatient/inpatient), format (group/ individual).

Participants. Inclusion and exclusion criteria, mean age, gender, ethnicity, method of diagnosis and comorbidity, OCD symptom severity, and treatment history (previous CBT treatment failure present/absent).

Intervention & comparators. Number of trial arms, type of intervention, therapy duration (i.e., session duration, therapy hours per week, total number of therapy hours, total number of weeks).

Outcome. Measures used (primary and secondary), change in OCD severity pre- and post-treatment and follow-up scores, time points reported, participant completion versus attrition, and use of intention to treat analysis.

Notes. Funding source, notable conflicts of interest.

Assessment of Risk of Bias in Included Studies

Each study was independently rated by two reviewers (JM and AB) using The Cochrane Collaboration's tool for assessing risk of bias in randomised trials (Higgins et al., 2011). The authors of the studies were contacted for further information where necessary.

The domains as specified by the Cochrane Collaboration tool were rated and judged to have either a 'low', 'high' or 'unclear' risk of bias. The domains included; 1) Selection bias (random sequence generation and allocation concealment), 2) Performance bias including (blinding of participants and personnel), 3) Detection Bias (blinding of outcome assessors), 4) Attrition bias (incomplete outcome data), 5) Reporting bias (selective reporting) and 6) Other sources of bias: Importance of Treatment Implementation (treating therapist factors and treatment fidelity). Quotations from each study were selected to support the judgement and the justification for each decision was documented (Table 1). Any discrepancies in risk of bias ratings were resolved by discussion between the reviewers and consultation with a third reviewer (SAP). Full details of the risk of bias rating domains and how they were applied to the included studies are presented in Appendix A.

Planned Methods of Analysis

Measure of Treatment Effect.

The primary outcome; the mean difference in change in OCD symptoms from baseline to follow-up between trial arms was measured by the Clinician administered version of the Y-BOCS (Goodman et al., 1989). Computation of effect size was done using Psychometrica software (Lenhard & Lenhard, 2016), applying the guidelines of Morris

(2007) for calculating effect sizes for repeated measures designs. The pooled pre-test standard deviation is used for weighting the differences of the pre-post means.

Acceptability.

Acceptability was defined as non-differential attrition, as calculated by the proportion of participants at follow-up minus the proportion of participants at baseline.

Results

Searches

Searches of all sources retrieved 5125 records. After duplicates were removed (*n* = 128) we screened 4997 titles and abstracts, 4923 of these were excluded. We screened 75 full texts records, 71 were excluded. The reasons for exclusion are: Participants (*n* = 3), Intervention (*n* = 48), Comparison (*n* = 12), other (*n* = 8) (See Table 2 for full details). We included four studies reported in six published manuscripts that met eligibility criteria (see Figure 1).

Ongoing Studies

Searches of clinical trial registers identified two ongoing studies (see Table 3 for details). We did not identify any completed, unpublished trials where the results were unavailable.

Participant characteristics

The combined sample size of the four studies was *N* = 313 participants, of which *n* = 248 met the inclusion criteria for this review (e.g. health controls arms were ineligible). The age range of participants was 18 to 70 years (*M* = 33.3 years). The mean percentage of women was 57.6% and ranged from 58% to 100%. No studies reported on the employment status of participants. Two studies reported on ethnicity with 84.7% of participants being white/ Caucasian (Challacombe et al., 2017; Foa et al., 2005). Three studies reported education level; however, each reported a different metric as follows: 67.5% of sample has degree level or above (Challacombe et al., 2017); sample mean of 15.6 years education (Moody et al, 2017); education levels of high = 56%, medium = 22% and low = 22% (Lindsay et al., 1997). Three studies reported relationship status with 61% of participants being married (25-98%) (Challacombe et al., 2017; Foa et al., 2005; Lindsay et al., 1997).

The mean Y-BOCS score across the four studies was 25.4 (*SD* = 0.83), indicating a severe level of OCD symptoms (Y-BOCS score of 24-31= Severe). Participants' history of previous treatment was not reported in two studies and formed an exclusion criterion in two studies [Foa et al., (2005) excluded participants who were considered to have had prior 'adequate' treatment with intensive ERP; Moody et al. (2017) excluded those with ≥30 sessions of prior CBT]. In addition, two studies applied the exclusion of the presence of major depression (Foa et al., 2005; Moody et al., 2017). Two studies reported on comorbidities within their sample, with 17.8% of the sample participants experiencing depression or dysthymia and 55.9% a comorbid anxiety disorder (Challacombe et al., 2017; Moody et al., 2017). For further symptom and demographic information, inclusion and exclusion criteria see Appendix A.

Study characteristics

All studies were RCTs, with individual-level randomisation. Follow-ups ranged from three weeks (Lindsay et al., 1997) to six months (Challacombe et al., 2017), mean duration 17.7 weeks. Two studies measured final outcomes at immediate completion of the intervention, with no follow-up (Lindsay et al., 1997; Moody et al., 2017).

Samples sizes ranged from *N* = 18 (Lindsay et al., 1997) to *N* = 116 participants (Foa et al., 2005). None of the studies reported using *a priori* power calculations to estimate the number of participants required prior to recruitment. However, Foa et al. (2005) reported that mid-trial preliminary analysis had indicated that a smaller placebo group was required for sufficient power. All studies recruited participants from clinical referrals for treatment of OCD, and three additionally recruited via internet advertisements and self-referral (Challacombe et al., 2017; Foa et al., 2005; Moody et al., 2017). Two trials were conducted in the USA (Foa et al., 2005; Moody et al., 2017), one in the UK (Challacombe et al., 2017) and one in Australia (Lindsay et al., 1997). All of the studies took place in outpatient clinics (Table 1).

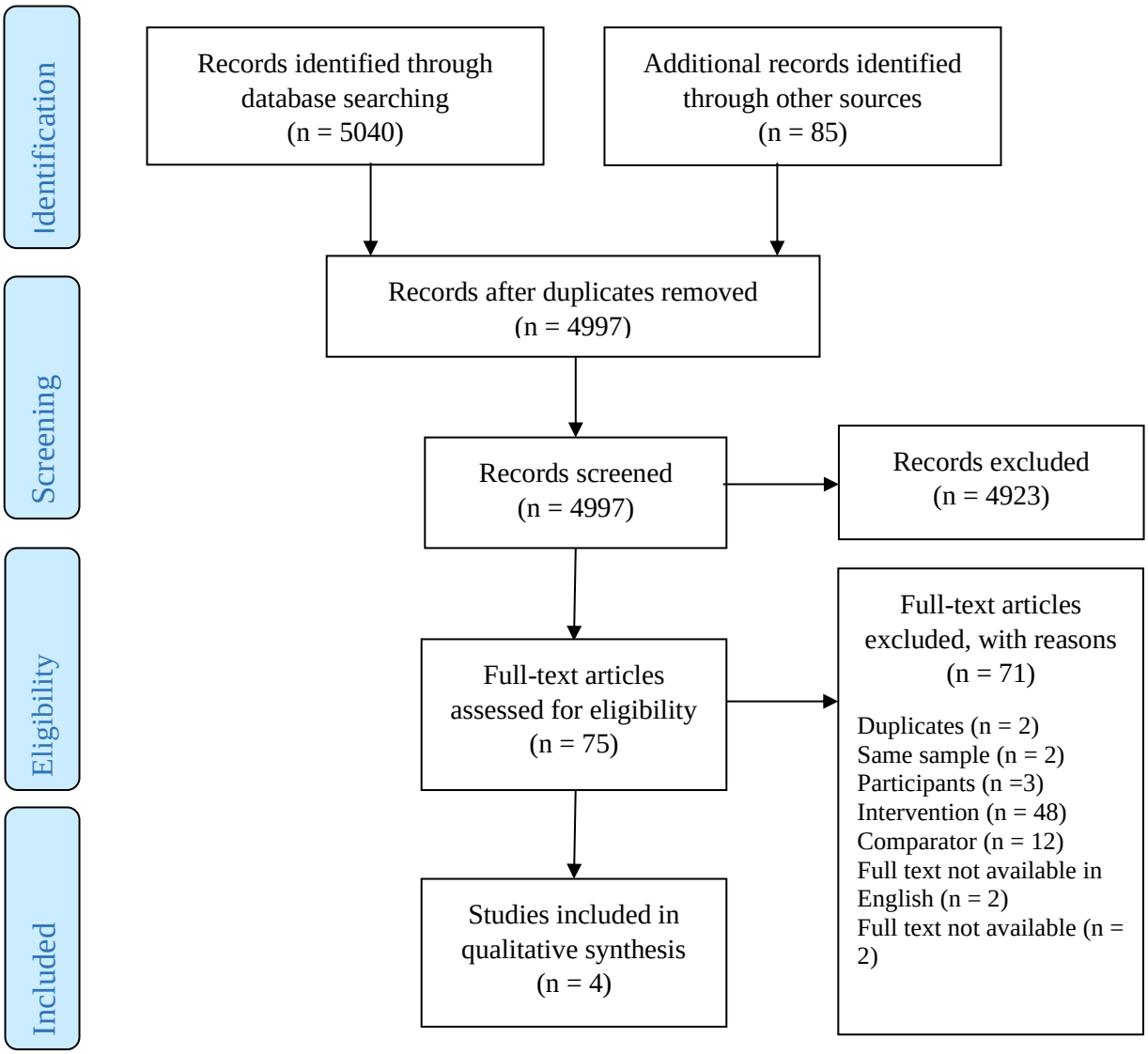

Figure 1. PRISMA diagram of study identification and selection.

Interventions

In all studies the intervention was delivered on a one-to-one basis. Three studies reported that the intervention was manualised, all of which described using iERP based on the habituation model rationale. The fourth reported using iCBT, with details on the intervention content not provided (Challacombe et al., 2017). Only one study reported testing treatment fidelity (adherence to manual and overall therapy quality) via video recordings of all consented therapy sessions (61%) which were rated by an independent evaluator (Moody et al., 2017). Lindsay et al. (1997) reported that treatment integrity was maintained by placing emphasis on adhering to the treatment manuals and agreeing what would be included in the treatment prior to its commencement.

Duration of intervention.

The duration of treatment was between two and four weeks. In three studies iCBT was delivered daily, with sessions ranging in length from one to two hours each (Foa et al., 2005; Lindsay et al., 1997; Moody et al., 2017). Challacombe et al. (2017) delivered two sessions a week of three hours each. Total therapy hours per week ranged from five to ten hours per week. Two studies provided a total of 30 hours of one-to-one therapist to participant intervention hours (Foa et al., 2005; Moody et al., 2017). Challacombe et al. (2017) and Lindsay et al. (1997) provided a total of 12 and 15 hours of one-to-one therapist to participant intervention hours, respectively.

Challacombe et al. (2017) offered participants three booster sessions at monthly intervals post treatment. Foa et al. (2005) provided two home visits and eight consolidation sessions of 45 minutes each on a weekly basis post treatment. Two studies did not report providing any follow-up sessions (Lindsay et al., 1997; Moody et al., 2017). The mean follow-up period was 2.25 months.

Therapist characteristics.

In three studies therapists delivering iCBT were reported to be qualified or licenced therapists who had extensive training and/or experience in treating OCD and received ongoing supervision throughout the trial (Challacombe et al., 2017; Foa et al., 2005; Moody et al., 2017). In one study therapists were specified as experienced clinical psychologists, there was no report of supervision (Lindsay et al., 1997).

Comparison groups.

Studies included an iCBT arm and the following comparators: wait list control (Moody et al., 2017); Treatment as Usual (Challacombe et al., 2017); active control (anxiety management, Lindsay et al., 1997); and multiple arms comprised of a) placebo, b) clomipramine, and an ineligible arm of c) clomipramine + intensive ERP (Foa et al., 2005). Two studies also included healthy control groups (Challacombe et al., 2017; Moody et al., 2017) to examine outcomes not relevant to this review.

Outcomes.

OCD symptoms: Three studies utilised the Clinician rated Y-BOCS as the primary outcome measure. One study did not specify a primary outcome measure and conducted a principal components analysis (with varimax rotation) utilising the Y-BOCS, The Maudsley Obsessional-Compulsive Inventory (MOCI) and The Padua Inventory (PADUA) as a combined measure of OCD symptom severity, reporting the combined and individual outcomes on these measures (Lindsay et al., 1997).

Acceptability: Two studies reported dropout rates during treatment (Challacombe et al., 2017; Moody et al., 2017) and one throughout the duration of the trial including follow-up (Foa et al., 2005). One study reported in the discussion section that there were no dropouts (Lindsay et al., 1997).

Risk of Bias in Included Studies

A risk of bias summary graph (Figure 2) and summary figure (Figure 3) are presented. For a detailed description of how each study was rated according to the risk of bias tool, see Appendix A. Overall there was relatively low risk of bias across studies. The most uncertain risk across studies uncertainty pertained to selection bias. The only evidence of a high risk of bias pertained to performance bias in one study.

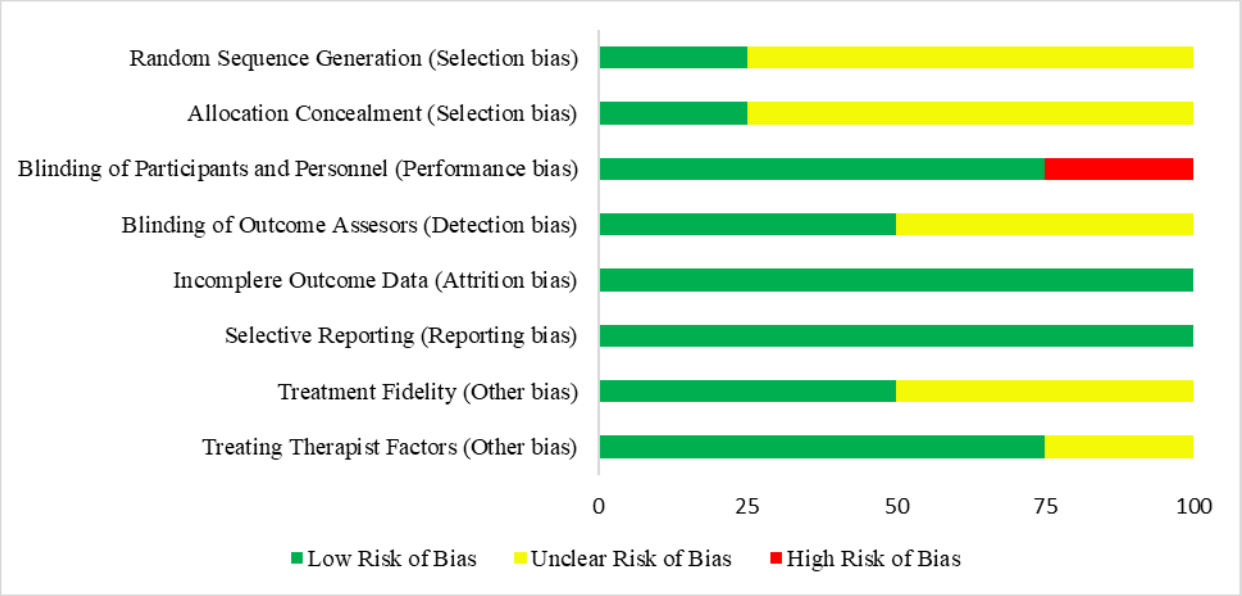

Figure 2. Risk of bias graph: review of authors' judgements about each risk of bias item presented as percentages across all included studies.

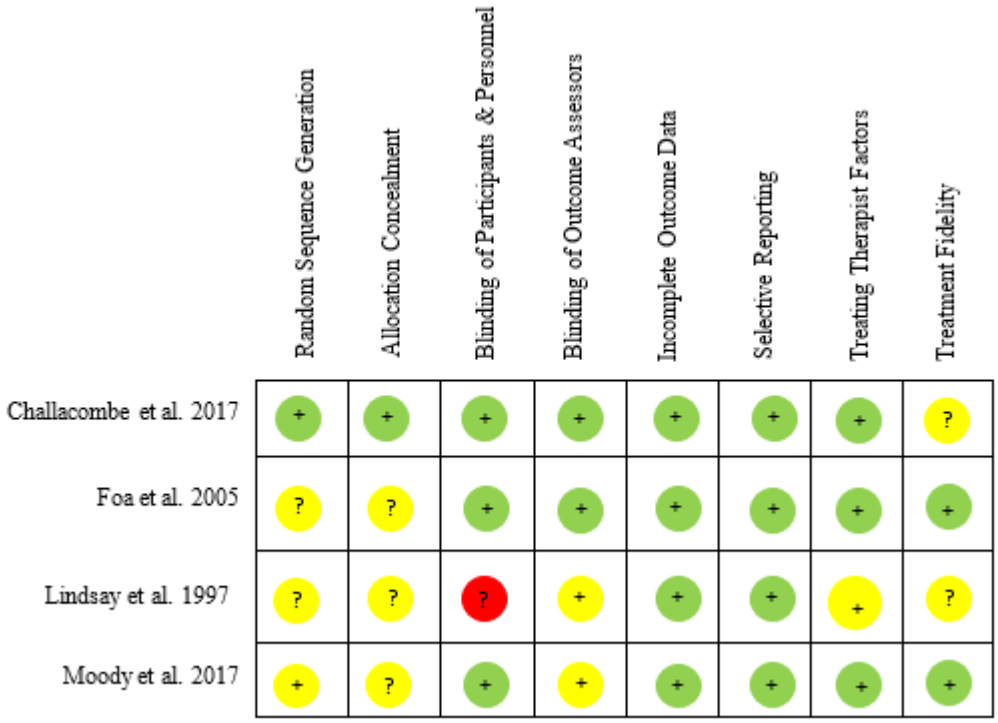

Figure 3. Risk of bias summary: review authors' judgements about each risk of bias item for each individual study.

Note: Red = high risk, yellow = unclear, green = low risk. Symbols indicate the level of agreement between the two independent reviewers. The + symbol = low risk, the ? symbol = unclear, the – symbol = high risk. The colour of the circle indicates the final judgement that was made.

Effects of interventions

Primary outcomes.

Table 4 provides a summary of findings for the primary and secondary outcomes. Where effect sizes were not provided by trial authors, they were computed by the review authors.

Comparison 1: iCBT vs weekly delivered CBT.

None of the included studies compared iCBT with weekly CBT.

Comparison 2: iCBT vs Treatment as Usual (TaU).

One study (N = 42) contributed data to this outcome (Challacombe et al., 2017). The iCBT group showed greater improvement when compared with the TaU group, with a large effect size reported (d = -1.32). Challacombe et al. (2017) reported that a 30% reduction on the Y-BOCS, which is considered to indicate a response to treatment. This was achieved by 70.5% (n = 12) of participants within the iCBT group and 18.8% (n = 3) of the TaU group.

Comparison 3: iCBT vs Wait list control.

One study (N = 43) contributed data to this outcome (Moody et al., 2017). The difference in YBOCS mean scores between the iCBT group and the wait list control group favoured iCBT at the end of treatment, with a large effect demonstrated (d = -1.80). No measure of clinically significant change was utilised by the trial authors.

Comparison 4: iCBT vs other active psychotherapy treatment.

One study (N = 18) contributed data to this outcome (Lindsay et al., 1997). The difference in YBOCS mean scores between the iCBT group and the Anxiety Management group favoured iCBT demonstrating a particularly large effect (d = -3.189). No measure of clinically significant change was utilised by the trial authors.

Comparison 5: ICBT vs Pharmaceutical interventions.

One study (N = 91) contributed data to this outcome (Foa et al., 2005). iCBT (iERP) was compared to both clomipramine (active pharmacological intervention) and pill placebo. iCBT outperformed both placebo (d = -2.42) and clomipramine (d = -1.195), each with large effect sizes for the difference in improvement.

Foa et al. (2005) also examined number of responders across conditions (defined as ratings of ‘much improved’ *or* ‘very much improved’ on the Clinical Global Impressions

Improvement scale (CGI-I). The iCBT condition and the clomipramine condition did not differ in the number of responders overall but the iCBT group did better when only those who completed treatment were considered. The iCBT condition had a greater number of excellent responders than the clomipramine condition in both the treated group and the completer group.

Secondary Outcome

Acceptability.

All four trials reported on study dropout. The proportion of eligible participants who declined to take part in the studies ranged from 0% to 63%, with a mean of 22.5%. The proportion of participants who dropped out after being randomised to receive iCBT was 9.1%, compared to 13% who were randomised to comparator condition. The rate of drop out among the 80 participants who commenced iCBT was 11.25% (range 0 to 27.5%) in comparison to 16.8% (range 0 to 25%) of the 113 participants in control conditions.

Discussion

Summary of main results

The aim of this systematic review was to assess the efficacy and acceptability of iCBT for adults with OCD. This review found four RCT's comparing iCBT for OCD with a control/ comparator condition. Each of the studies used a different control/ comparison intervention and some studies had specific populations (i.e. perinatal OCD) and therefore it was not feasible to combine study data in a meaningful way to conduct a meta-analysis. However, this review builds on the only other systematic review examining intensive treatments for OCD (Jónsson et al., 2015) which only included two RCTs of adults with OCD. A summary of the main findings follows. The first research question concerned the effectiveness of iCBT for OCD. A large effect was found in favour of iCBT across all of the included studies when compared to the comparator within the trial. However, comparator conditions were extremely variable across studies, and no study compared iCBT to standard format CBT. As such no definitive conclusions can be drawn regarding the superiority of iCBT over CBT.

The second question of this review concerned acceptability of iCBT. The mean rates of drop out were particularly low within the included studies, with no evidence for differential attrition. Only one study had a rate greater than 20% (Foa et al., 2005). However, within this study there were no differences in attrition rates across groups and reasons for

attrition were reported in full. We can be confident that the risk of attrition bias was low across the included studies of this review, and that there were not differences between participants who completed versus those who dropped out which could have affected treatment outcomes. Within the literature rates of attrition are cited as between 20% (Schruers, Koning, Luermans, Haack, & Griez, 2005) and 25% (Abramowitz, Taylor & McKay, 2009). However, some authors cite attrition rates of up to 50% (e.g. Franklin & Foa, 1998 as cited in Abramowitz & Arch, 2014), along with estimates reported by therapists' of up to 40% in clinical practice (Swift & Greenberg, 2012). More recent meta-analysis indicate mean dropout rates of approximately 15% (Ong, Clyde, Bluett, Levin, & Twohig, 2016; Öst et al., 2015) dispelling the idea that CBT is hard to tolerate and often unacceptable to patients.

Rates of refusal to undertake CBT in OCD have been cited to be up to 25% in existing trials for standard format delivery (Schruers et al., 2005). The rate of declining CBT within the included studies compared favourably to this. Although not generalizable, it appears that iCBT is comparable to standard format CBT in terms of acceptability.

Only one previous review has addressed the efficacy of iCBT (Jónsson et al., 2015). This review examined the evidence for both children and adults and conducted a combined meta-analysis which included 17 studies of which only three were RCTs. Jónsson et al. (2015) reported effect sizes of between $d = 1.31$ and $d = 5.29$ for iCBT concluding that there was some support for the superiority of iCBT over standard CBT. Jónsson et al. (2015) asserted that the results of the review were not reliant on low quality studies due to the non-significant difference between pooled effect sizes of randomised and non-randomised studies. We suggest that the results of this review are interpreted with caution due to the significant limitations of the studies included in the meta-analysis, as noted by Jónsson et al. (2015). Of greatest concern are the threats to validity and risks of bias. For example, the extensive heterogeneity within the studies which were not reduced by sensitivity analysis, the small sample sizes in the majority of included studies, and a reliance on reporting completer data. It is well established that a meta-analysis of results from less rigorous studies varying in validity can be considered to be at greater risk of false positive conclusions if the studies are biased towards overestimating the effect of an intervention (Detsky, Naylor, O'Rourke, McGeer, & L'Abbé, 1992). There are significant limitations and thus we suggest that caution is applied when drawing any conclusions, further research is required.

There are several gaps within the evidence with regards to the trials that have been conducted to date for iCBT which are important to consider. Firstly, the treatment history of

participants, secondly the settings in which the interventions took place and finally the length of follow-up post intervention.

The participants in the included studies would not meet the NICE criteria for which an intensive version of CBT is currently recommended (NICE, 2005, 2013). Participants who had previously received what was deemed as an adequate amount of previous CBT or pharmacological intervention were excluded from two of the trials (Foa et al., 2005; Moody et al., 2017). However, such exclusion criteria are in fact the criteria for which the NICE guidance recommends an intensive format. It is therefore not possible to draw any substantial conclusions about the efficacy or the acceptability of this approach for the patient group for whom the NICE recommendation is in place.

It should be noted that Challacombe et al. (2017) did not exclude participants based on treatment history, however the participants within this trial were mothers who had given birth within the previous six months, with a large proportion experiencing OCD specific to the birth. Secondly, all of the studies took place within outpatient settings thus no conclusions can be drawn here about the efficacy of iCBT delivered in inpatient settings. Thirdly, when considering a format of CBT that is condensed in terms of the number of weeks/ months over which is it is delivered, it is important that long terms outcomes are considered. The included studies within this review provided minimal follow-up and thus are not sufficient to enable comment on the longevity of reported effects.

Quality of the evidence

The majority of studies failed to describe their randomisation procedures adequately, and thus it was not possible to fully assess the extent to which selection bias may have occurred in the included studies. Blinding of therapists and participants in psychotherapy trials is generally not possible. However, attempts can be made to reduce contamination between groups (see Appendix A, 1.4.6), which was not demonstrated within the included trials. By contrast, blinding of assessors in psychotherapy trials is feasible, yet minimal information was provided regarding the blinding of assessors within the information collection process, making the extent to which detection bias was likely to have occurred across the studies unclear.

The risk of reporting bias was also generally low across studies, although treatment protocols were not published for most included studies, there was consistency between outcomes in the methods and results. Intention to treat analysis was utilised, although the anomaly was Moody et al. (2017) who only reported completer data.

Although most of the included studies utilised experienced therapists, only one study reported the results of treatment fidelity checks. The extent to which therapists were therefore adhering to the treatment is unclear and thus increases the uncertainly as to whether observed treatment effects can be attributed directly to the components of the intervention.

Heterogeneity of the results of studies can be explained somewhat by differences in risks of bias and considerations of other methodological factors. In a meta-analysis conducted by (Öst, 2014) a significant association was found between low methodological stringency and high effect size. As methodological quality can be split into three main areas (risk of bias, generalisability, precision and other aspects e.g. ethical considerations) whilst a rigorous assessment of risk of bias was undertaken, other aspects of methodological rigour were not systematically evaluated beyond this. Applying a measure of methodological rigour (e.g. the psychotherapy outcome study methodology rating scale (POSMRS), Öst, 2008) may have been useful for further interpreting the validity of individual studies and their findings. For example, the POSMRS specifically reviews aspects including reliability of the diagnosis, power analysis, statistical analyses and presentation of results, clinical significance etc. which were not systematically considered here.

Potential biases in the review process

Strengths.

A strength of this review is the rigorous search strategy that was employed to locate all possible evidence and efforts made to contact trial authors for missing information. Searches of published and unpublished material were made. It is likely that all eligible trials conducted to date have been included and that the risk of conclusions being skewed by publication bias has been minimised. An additional strength is the transparency of the review methods utilised. Three review authors were independently involved in each phase of the review.

Limitations.

Although extensive efforts were made to obtain missing data and information required, this was not possible in all cases and thus it is acknowledged that included studies may not be represented fully within all aspects of the review.

We acknowledge the limitations of using attrition rates as a measure of acceptability, as there can be other factors that lead to attrition (e.g., demographic variables; including race, cultural background, specifically lower socioeconomic status and lower levels of

educational attainment (Roseborough, McLeod, & Wright, 2016)). Equally, participants may continue with therapy despite low satisfaction.

Clinical implications

The studies that have been conducted to date are inconclusive therefore it is not possible to make specific clinical recommendations in the absence of further well controlled trials. The low dropout rate in iCBT across studies in this review is consistent with previous meta-analysis (Jónsson et al., 2015; Öst et al., 2015). It is important that the misconception of contemporary CBT for OCD being difficult to tolerate and likely to be unacceptable to a large proportion of patients (e.g. dropout rates of up to 50%) is not perpetuated. Such citations within the literature are outdated and can no longer be substantiated. They are also unhelpful to both therapists delivering CBT and patients seeking or undertaking treatment alike.

Conclusion

Although a meta-analysis was not performed, the effect of iCBT appears to have evidence of promise for efficacy, and iCBT appears to be acceptable. Further high quality RCTs are required to conduct a meta-analysis to examine the efficacy and acceptability of iCBT for the group of OCD sufferers for whom the NICE guidelines recommend an intensive version of CBT.

Funding

No funding was obtained for the preparation of this review.

Contributors

JM carried out the literature search. The initial screen and full text screen was conducted by JM and the second independent review was completed by SAP and AB who screened 50% of the initial screen each. The full text screen was completed by JM and AB. Data extraction was done by JM and SAP and checked by AB. The Cochrane Risk of Bias assessment was carried out by JM and AB and checked by SAP. All authors contributed to the editing and revision of the manuscript and approved the final manuscript.

Acknowledgements

The authors would like to thank Gemma Taylor and James Gregory for their comments on the final manuscript.

Conflict of interest. None of the authors have any conflict of interest to report.

Table 1.

Characteristics of included studies

Challacombe et al., 2017

Methods	**Study design:** RCT **Duration of study:** Not reported **Study dates:** Not reported
Participants	**Setting:** Single site, outpatient (UK) **Sample population:** Recruited via advertisements on UK-based OCD service user networks, parenting websites and within local clinical services **Participants randomised:** *N* = 42 **Sample size:** *N* = 42 OCD, (*N* = 37 Healthy Control) **Inclusion criteria:** Diagnosis of OCD (DSM-IV), Mother of a baby < 6 months old **Exclusion criteria:** OCD not primary diagnosis, psychosis, alcohol or substance abuse, twins, refusal to be videotaped
Intervention	**1. iCBT:** 2 weeks, 4 sessions, 3 hrs each (6hrs/w). Total CBT hours: 12 hours. **2. Treatment as** Usual (i.e. some CBT (*N* = 6); mindfulness (*N* = 3); Counselling (*N* = 2); No treatment (*N* = 2). **3. Healthy Controls** (not included in this review).
Outcomes	**Measures relevant to review:** Clinician-rated YBOCS **All other measures:** The Ainsworth sensitivity scale, Strange Situation Procedure, Obsessive Compulsive Inventory, Ainsworth cooperation–intrusiveness scale, maternal warmth, vocalizations and over conscientious behaviours (M Ainsworth, unpublished scales), Self-Efficacy Scale, GRIMS and DASS. **Follow-up times:** 6 and 12 months of babies age.
Notes	**Funding:** Peggy Pollak Research Fellowship from the Psychiatry Research Trust, Institute of Psychiatry, Psychology and Neuroscience. **Trial authors declaration of interest:** None.

Risk of Bias		
Bias	**Author's judgement**	**Support for judgement**
Selection Bias		
Random sequence allocation	Low risk	**Quote:** "A random sequence of the two treatment categories was generated in blocks of six (www.randomization.com)".
Allocation concealment	Low risk	**Quote**: "A person unconnected with the study sealed cards with each category in numbered individual envelopes". "The researchers and participants were blind to group allocation until the envelope was opened at the end of the baseline assessment". **Quote**: "The TAU group was significantly higher in dimensionally measured anxiety on the DASS scale. Otherwise, the two clinical groups were well matched". **Quote:** (from correspondence) "envelopes were opaque".
Performance Bias		
Blinding of participants and personnel	Low risk	**Quote**: The study did not address this outcome. However, due to design of CBT Vs TaU, it is not possible to blind participants or personnel to the intervention during the study.
Detection Bias		
Blinding of outcome assessors	Low risk	**Quote**: "The outcome/12-month assessment was conducted by a researcher who was blind to group allocation and was not in any way involved in the therapy".
Attrition bias		
Incomplete outcome data	Low risk	**Quote**: "One mother in the iCBT group did not complete treatment but did complete assessments and was included in all analyses".

Reporting Bias		
Selective reporting	Low risk	**Comment**: The study protocol is not available; however, the published report includes all expected outcomes apart from the outcomes of the 'perceived social support scale' which are not relevant to this review.
Other Bias		
Therapist qualifications, training, supervision and treatment fidelity.	Unclear	**Quote:** "iCBT was predominantly delivered by the first author (F.L.C.) who is a qualified clinician, who received ongoing supervision in CBT for OCD for the duration of the study…. were treated by two other qualified experienced therapists specializing in OCD…".

Foa et al., 2005	
Methods	**Study design:** RCT **Duration of study:** 10 years **Study dates:** 1990–2000.
Participants	**Setting:** Three site, outpatient (Philadelphia, New York, and at the satellite site in Winnipeg USA). **Sample population:** recruited through self-referrals, professional referrals, and media advertisements and needed to live within a commutable distance from their study site. **Participant screened:** *N* = 833 **Participants not eligible:** *N* = 312 **Participants declined participation:** *N* = 372 **Participants randomised:** *N* = 149 **DROP OUT: during treatment** **iERP:** *N* = 8 (*withdrew after learned condition)* **C:** *N* = 11 *(withdrew after learned condition)* **iERP + C:** *N* = 2 *(withdrew after learned condition)* **P:** *N* = 6 *(withdrew after learned condition)* **Sample size:** *N* **=** 122

	Inclusion criteria: Age 18–70 years, diagnosis of OCD (DSM-III-R/ DSM-IV), OCD is primary problem, Y-BOCS total score ≥ 16, Illness duration ≥ 1 year. **Exclusion criteria:** Other primary or co-primary psychiatric disorder Current Major Depression: HDRS >18, prominent suicidal ideation, alcohol or substance dependence in past 6 months, current schizotypal or borderline personality disorder, Past adequate treatment with clomipramine (≥150 mg/day for more than 4 weeks), Prior adequate treatment with intensive ERP (>3 visits per week for more than 2 weeks), significant abnormalities in ECG.
Intervention	**1. Intensive Exposure and Response Prevention (iERP)**: 3 weeks, daily sessions, 2 hrs each (10hrs/w) plus HW of 2 hours per day. Total therapy hours: 15 sessions (30 hours). **2. iERP + Clomipramine:** both treatments undertaken simultaneously (not eligible for this review). **3. Clomipramine:** weekly 30min session for medication review. **4. Placebo:** weekly 30min session for medication review.
Outcomes	**Measures relevant to review:** Clinician-rated YBOCS. **All other measures:** Clinical Global Impression-Improvement scale (CGI-I), Clinical Global Impression-Severity scale (CGI-S), Hamilton Depression Rating Scale.
Notes	**Funding:** NIMH grants MH-45404 and MH-45436 **Trial authors declaration of interest:** Not reported

Risk of Bias

Bias	**Author's judgement**	**Support for judgement**
Selection Bias		
Random sequence allocation	Unclear risk	**Quote**: "Treatment assignment was done randomly within blocks of four".

		Comment: Insufficient information about the random component of the sequence generation process.
Allocation concealment	Unclear risk	**Quote**: "The only pre-treatment difference between patients at the three sites was in the NIMH Global Obsessive-Compulsive Scale score (the mean score for the Philadelphia site was higher than that for the New York site, $F = 4.93$, $df = 1, 105$, $p < 0.05$). There were no other differences among conditions or sites on demographic variables nor in pre-treatment scores on the Yale-Brown Obsessive-Compulsive Scale" **Comment**: Method of concealment is not described.
Performance Bias		
Blinding of participants and personnel	Low risk	**Quote**: "Psychiatrists were blind to patients' medication assignment and therapy status. The therapists who provided exposure and ritual prevention were blind to patients' medication status".
Detection Bias		
Blinding of outcome assessors	Unclear	**Quote**: "Independent evaluators, who remained blind to treatment assignment, conducted the assessments". **Comment**: The relationship of the independent evaluator to the study is not specified.
Attrition bias		
Incomplete outcome data	Low risk	**Quote:** "The overall dropout rate of those entering treatment was 29%. There were no differences in rates across conditions ($\chi 2 = 1.9$, $df = 3$, $p = 0.58$), and patients dropped for various reasons."; "Patients who dropped out of the study did not differ from completers on demographic or clinical

		characteristics, including OCD severity. The majority (82%) of dropouts occurred within the first 4 weeks, with no differences in the number of weeks completed before dropout across conditions or sites. However, New York had significantly more dropouts than Philadelphia (26 (43%) versus 10 (16%); $\chi 2 = 10.4$, $df = 1$, $p = 0.001$)". **Quote:** "…data were not collected on patients who dropped out of treatment after randomization but before treatment, and they could not be included in last-observation-carried-forward analyses". **Comment:** Reasons are unlikely to be related to true outcome; balanced in numbers across intervention groups.
Reporting Bias		
Selective reporting	Low risk	**Comment**: The study protocol is not available, but the published report includes all expected outcomes.
Other Bias		
Therapist qualifications, training, supervision and treatment fidelity.	Low risk	**Quote:** "…we used a manual-based, empirically validated version of exposure and ritual prevention". **Quote:** "ERP therapists received training and ongoing weekly supervision. Training included observing experts who conducted exposure and ritual prevention and completing at least one training case of exposure and ritual prevention". **Quote:** "Independent evaluators received training and ongoing supervision from Philadelphia faculty and performed practice ratings of taped interviews intermittently during the study". **Quote:** "each site conducted all treatments after extensive training and with ongoing supervision of research staff, we sought to ensure that treatments

	were consistently administered in an expert fashion across sites". **Quote:** "Throughout, independent evaluators from New York and Philadelphia met to discuss assessment issues and rated specific assessments together to ensure interrater reliability. Before each assessment by the independent evaluator, patients were reminded not to discuss their treatment in order to maintain the blind".

Lindsay et al., 1997

Methods	**Study design:** RCT **Duration of study:** Not reported **Study dates:** Not reported
Participants	**Setting:** Single site, outpatient (Australia) **Sample population:** Not specified **Participants randomised:** *N* = 18 **Sample size:** *N* = 18 **Inclusion criteria:** Diagnosis of OCD DSM-IV (no specific inclusion criteria specified apart from diagnosis of OCD) **Exclusion criteria:** None specified
Intervention	**iERP:** 3 weeks, daily sessions, 1hr each (5hrs/w) Total iERP hours: 15 hours (15 sessions) **Anxiety Management:** 3 weeks, daily sessions, 1hr each (5hrs/w)
Outcomes	**Measures relevant to review:** Clinician-rated YBOCS **All other measures:** The Padua Inventory (PADUA), The Maudsley Obsessional-Compulsive Inventory (MOCI), The State Trait Anxiety Inventory, Beck Depression Inventory.
Notes	**Funding:** Not reported **Trial authors declaration of interest:** Not reported

Risk of Bias		
Bias	**Author's judgement**	**Support for judgement**
Selection Bias		
Random sequence allocation	Unclear risk	**Quote**: "Subjects were randomly assigned to one of two treatment conditions". **Comment**: Insufficient information about the random component of the sequence generation process.
Allocation concealment	Unclear risk	**Quote** "There was no significant difference between the groups on any of these measures". **Comment**: Method of concealment is not described.
Performance Bias		
Blinding of participants and personnel	High risk	**Quote**: "… to rule out the possibility that any observed differences in treatment outcome were due to differences in therapist variables, patients were contacted following treatment and asked to rate their therapist for two qualities: supportiveness and understanding. These interviews were conducted over the phone by an independent assessor". **Comment**: It is not stated if the independent assessor was involved in the study in other ways **Comment**: The study did not address this outcome.
Detection Bias		
Blinding of outcome assessors	Unclear risk	**Comment**: The study did not directly address outcome assessors.
Attrition bias		
Incomplete outcome data	Low risk	**Quote:** "No patients dropped out of treatment". **Comment:** This was stated in the discussion.

Reporting Bias		
Selective reporting	Low risk	**Comment**: The study protocol is not available, but the published report includes all expected outcomes.
Other Bias		
Therapist qualifications, training, supervision and treatment fidelity.	Unclear risk	**Quote:** "…with experienced Clinical psychologists". **Quote:** "All subjects received a treatment manual which outlined in detail a rationale for treatment and treatment guidelines". OCD treatment manual: "Andrews et al., 1994", Anxiety management "manual was derived from the GAD manual in Andrews et al., 1994". **Quote:** "Treatment integrity was maintained by emphasising close adherence to the treatment guidelines provided in the treatment manuals. In addition, the structure and content of therapy sessions for both groups were agreed upon by all clinicians before the study began". **Comment:** Supervision of therapists was not specified.

Moody et al., 2017

Methods	**Study design:** RCT **Duration of study:** Not reported **Study dates:** Not reported
Participants	**Setting:** Single site, Outpatient. **Sample population:** Recruited participants through UCLA clinics, flyers, and internet advertisements. **Participants randomised:** *N* = 51 **Sample size:** *N* = 239 OCD screened for eligibility, *N* = 71 assessed by physician *(N = 18 did not meet inclusion, N = 2 declined to participate)*

	Inclusion criteria: Diagnosis of OCD (DSM-IV), Y-BOCS total score ≥16, age of onset before age 18. **Exclusion criteria:** Psychotic disorders, Bipolar disorder**,** Lifetime substance dependence, ADHD Severe depression: ADIS-IV ≥ 6 No changes in SSRI medication within 12 weeks prior to enrolment ≥ 30 sessions of prior CBT.	
Intervention	**1. iCBT**: 4 weeks, daily sessions, 1.5hrs each (7.5hrs/w). Total Intervention hours: 30 hours within 20 sessions. **2. Wait list control:** 4-week wait before iCBT (as described). **3. Healthy control** (not relevant to this review).	
Outcomes	**Measures relevant to review:** Clinician-rated YBOCS. **All other measures:** OCI-R, Hamilton Anxiety Scale (HAMA), Montgomery-Åsberg Depression Rating Scale (MADRS), Global Assessment Scale (GAS)	
Notes	**Funding:** National Institute of Mental Health R01MH058900 **Trial authors declaration of interest:** None.	
Risk of Bias		
Bias	**Author's judgement**	**Support for judgement**
Selection Bias		
Random sequence allocation	Unclear risk	**Quote**: "We used randomized permuted blocking with blocks size of 4 and covariate-adaptive randomization for medication status, gender and age" **Comment**: Insufficient information about the random component of the sequence generation process.
Allocation concealment	Unclear risk	**Comment**: Method of concealment is not described.

Performance Bias		
Blinding of participants and personnel	Low risk	**Comment**: The study did not address this outcome. However, due to design of CBT Vs waitlist control, it is not possible to blind participants or personnel to the intervention during the study.
Detection Bias		
Blinding of outcome assessors	Low risk	**Quote**: "Independent evaluators not involved in treatment or assessments administered psychometric instruments". **Comment**: "Outcome" assessors are not directly specified. **Comment**: The blinding and relationship of the independent evaluator to the study is not specified.
Attrition bias		
Incomplete outcome data	Low risk	**Quote:** "Four waitlist-first participants elected to withdraw before finishing waitlist and 1 was withdrawn due to medication protocol violation. The study physician withdrew 2 treatment-first participants, and 1 completed the study but had inadequate data due to head motion". **Comment:** Only participant completer data was used in analysis.
Reporting Bias		
Selective reporting	Low risk	**Comment**: The published study is in line with the study protocol.
Other Bias		
Therapist qualifications, training, supervision and treatment fidelity.	Low risk	**Quote:** "All OCD participants underwent manualized exposure and response prevention (ERP)-based iCBT". **Quote:** "Two licensed therapists with extensive training in CBT for OCD conducted treatment. Both had 6 or more years of specialty training in intensive and outpatient CBT for OCD".

Quote: "Therapy sessions of consenting participants (61%) were videotaped, and an independent evaluator (also a trained CBT therapist with 8 years' experience) rated all sessions for quality assurance, including adherence to the manual and overall quality of the session. Average treatment adherence was 97.7% and average quality of sessions was 9.96 (0–10 scale)".

Comment: Supervision of therapists not specified, however probable, given therapy assurance checks described.

Table 2.

Characteristics of excluded studies

Study	**Reason for exclusion**
Adams et al., 2012	Intervention
Aderka et al., 2012	Intervention
Alcolado et al., 2016	Intervention
Asnaani et al., 2017	Intervention
Baruah et al., 2018	Intervention
Behenck et al., 2016	Intervention
Belloch et al., 2008	Intervention
Belloch et al., 2008	Duplicate
Braga et al., 2005	Intervention
Cabedo et al., 2010	Intervention
Chasson et al., 2010	
Cottraux et al., 2004	No access
Cottraux et al., 2001	Intervention
deAraujo et al., 1995	Intervention
Demal et al., 1996	Intervention
Dèttore et al., 2013	Intervention
Diefenbach et al., 2007	Comparator
Dogan et al., 2012	No access
Emmelkamp et al., 1991	Intervention
Foa et al., 1980	Comparator
Freeston et al., 1997	Intervention
Gomes et al., 2016	Intervention
Gomes et al., 2017	Intervention
Gomes et al., 2014	Comparator
Hansen et al., 2007	Intervention
Herbst et al., 2014	Intervention
Hiss et al., 1994	Intervention
Hu et al., 2015	Intervention
Hu et al., 2012	Intervention
Jaurrieta et al., 2008	Intervention
Jaurrieta et al., 2008	Duplicate
Jelinek et al., 2018	Intervention

Jonsson et al., 2011	Intervention	
Jónsson et al., 2011	Comparator	
Kampman et al., 2002	Intervention	
Kearns et al., 2010	Comparator	
Kellner et al., 2016	Intervention	
Kordon et al., 2005	Comparator	
Lovell et al., 2017	Intervention	
Lovell et al., 2017	Intervention	
Ma et al., 2013	Comparator	
Mahoney et al., 2014	Intervention	
Marsden et al., 2018	Intervention	
McLean et al., 2001	Intervention	
Mehta et al., 1990	Participants	
Meyer et al., 2010	Intervention	
Mitchell et al., 2006	Participants	
Motivala et al., 2018	Duplicate	
Mohsendadashi et al., 2018	No access	Full text only available in Hebrew
Nakao et al., 2005	No access	Full text only available in Japanese
O'Connor et al., 1999	Intervention	
O'Neill et al., 2013	Comparator	
Ogrodniczuk et al., 2005	Comparator	
Olatunji et al., 2013	Intervention	
Rector et al., 2018	Intervention	
Rector et al., 2009	Participants	
Reggente 2018	Duplicate	
Rufer et al., 2004	Intervention	
Shikatani et al., 2016	Comparator	
Shinmei et al., 2017	Comparator	
Simpson et al., 2012	Intervention	
Simpson et al., 2010	Intervention	
Thiel et al., 2014	Intervention	
Thompson-Hollands et al., 2015	Intervention	
Tundo et al., 2011	Intervention	
Vogel et al., 2006	Intervention	
Vos et al., 2012	Intervention	

Whittal et al., 2008	Intervention
Whittal et al., 2010	Intervention
Wootton et al., 2013	Intervention
Zhao et al., 2017	Intervention

Table 3.

Characteristics of ongoing studies

Trial name of title	Concentrated Exposure Treatment (cET) for Obsessive Compulsive Disorder (OCD). A Randomized Controlled Trial (RCT) ClinicalTrials.gov Identifier: NCT02886780
Methods	A randomized controlled trial comparing the 4-day format with a self-help programme and waiting list. The study will be conducted at Solvang DPS, Sørlandet Hospital. Participants (16 in each group) are ordinary patients (>18 yrs.) entitled to care in the specialist health care.
Participants	**Inclusion Criteria:** OCD-patients referred to the OCD-team at Sørlandet Sykehus, ≥ 18 years of age, fulfilling DSM-5 OCD diagnostic criteria, Y-BOCS ≥ 16, Fluent in Norwegian, signed informed consent **Exclusion Criteria:** OCD symptoms primarily associated with hoarding, ongoing substance abuse/dependence, bipolar disorder or psychosis, ongoing suicidal ideation, mental retardation based on previous medical history. If using antidepressants: not on stable dosage 4 weeks before the intervention, unwilling to remain on stable dosage during the four intervention days, unwilling to refrain from anxiety reducing substances, such as anxiolytics (e.g. benzodiazepines) and alcohol during the two days of exposure, patients living > 1.5 hour drive by car/ train from the treatment location, patients with a BMI-index considered too low for participation in psychological treatment, Patients with a full course of prior CBT for OCD.
Intervention	Concentrated ERP delivered in a group setting over 4 days.
Comparator	Self-help condition (SH) (Foa, E.B. & Kozak, M.J. Mastery of obsessive-compulsive disorder: Client workbook, (Graywind Publications, New York, 1997).
Outcomes	Changes in Y-BOCS from pre cET-treatment to post treatment/ waiting list/ self-help [Time Frame: Pre-treatment, 1-week post, minimum nine weeks after pre-treatment, minimum six months follow-up]

	Changes in OCD diagnostic status (DSM-5) as measured by SCID [Time Frame: Pre-treatment, 1 week post, minimum nine weeks after pre-treatment, minimum six months follow-up]
Starting date	September 2016
Contact Information	Gerd Kvale, Haukeland University Hospital

Trial name of title	Examining the Feasibility and Acceptability of Good Quality ICBT for OCD and Good Quality Weekly CBT for OCD
Methods	The two different treatment formats are CBT delivered on a weekly basis (which is approximately 12-18 hours of therapy delivered weekly for 60-90 minutes each session, followed by 1-3 monthly follow-up sessions as needed) and CBT offered in an intensive format (which is having approximately 12-18 hours of therapy all in a 3-week period, followed by 1-3 monthly follow-up sessions as needed).
Participants	**Inclusion Criteria:** Primary diagnosis of OCD (as confirmed by the administration of the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, 4th ed.) (DSM-IV) (SCID-I). Participant identifies their main problem as OCD. Participant has not responded to one or more trials CBT. Yale-Brown Obsessive-Compulsive Scale (YBOCS) score of 16 or above. No change in psychotropic medication (if applicable) for at least 8 weeks prior to study entry. (If such a change has taken place there will be an option for the participant to take part once the medication has been stabilised). No intention to change psychotropic medication during the course of the trial. Able to speak and read every day English. **Exclusion Criteria:** Severe psychiatric problem that requires separate treatment at an immediate basis and is linked to risk. Drug and/or alcohol dependence in last three months History of Psychosis or Bipolar Disorder
Intervention	Intensive Cognitive Behavioural Therapy (an average of 12-18 hours of CBT offered in an intensive format, delivered on 2-3 days per week over a period of 3 weeks).

Comparator	Active Comparator: Weekly Cognitive Behavioural Therapy (an average of 12-18 hours of CBT delivered in 60-90-minute sessions on a weekly basis) No Intervention: Wait list Wait list (3 months). Participants randomized to wait list will commence treatment after 3 months, in the treatment condition to which they are re-randomized (either Intensive or Weekly CBT).
Outcomes	Yale- Brown Obsessive Compulsive Scale (Y-BOCS) & Obsessive-Compulsive Inventory (OCI) [Time Frame: Assessment, end of treatment (at 3 weeks for Intensive & 12-15 weeks for weekly treatment) and follow-up (at 3 & 6-months post treatment completion for both groups)]
Starting date	August 15, 2014
Contact Information	Josie Millar, University of Bath

Table 4: *Summary of findings: Y-BOCS pre and post mean scores effect size, clinically significant change and Drop out*

Challacombe et al. (2017)		**iCBT**		**Treatment as Usual (TaU)**				**iCBT**	**TaU**	**iCBT**	**TaU**
	Time point	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**Effect size**		**Clinically Significant Change**		**Drop Out**	
	Pre: Baseline	17	24.82 (5.20)	17	24.47 (5.81)	(*d* = - 1.352)	30% Y-BOCS	**N (%)**	**N (%)**	**N (%)**	**N (%)**
	Post: 6mths	17	13.71 (8.95)	16	20.88 (6.34)		reduction	12	3	1 (5.8)	0 (0)
	Mean difference		11.11		3.59		Mean Y-BOCS	**M (SD)**	**M (SD)**		
							gp reduction	48.4% (25.2)	12.8% (22.6)		
Lindsay et al. (1997)		**iERP**		**Anxiety Management (AM)**				**iERP**	**AM**	**iERP**	**AM**
	Time point	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**Effect size**		**Clinically Significant Change**		**Drop Out**	
	Pre: Week 0	9	28.70 (4.56)	9	24.44 (6.98)		-	- -	- -	**N (%)**	**N (%)**
	Post: Week 4	9	11.00 (3.81)	9	25.89 (5.80)	*d* = - 3.189				0 (0)	0 (0)
	Mean difference		17.7		-1.45		Mean Y-BOCS	**M (SD)**	**M (SD)**		
							gp reduction	61.7% (NR)	- -		
Moody et al. (2017)		**iCBT/ERP**		**Waitlist Control (WC)**				**iCBT/ERP**	**WC**	**iCBT/ERP**	**WC**
	Time point	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**Effect size**		**Clinically Significant Change**		**Drop Out**	
	Pre: Week 0	43*	24.5 (4.7)	21	25.6 (4.9)		-	-	-	**N (%)**	**N (%)**
	Post: Week 3	43*	15.0 (5.2)	21	24.7 (5.4)	*d* = - 1.797	Mean Y-BOCS	**M (SD)**	**M (SD)**	0 (0)	4 (16.6)
	Mean difference		9.7 (5.8)		0.90 (3.1)		gp reduction	39.6% NR	3.5% NR		
Foa et al. (2005)		**iERP**		**Clomipramine (C)**				**iERP**	**C**	**iERP**	**C**
iERP vs C	**Time point**	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**Effect size**		**Clinically Significant Change**		**Drop Out**	
	Pre: Week 0	29	24.6 (4.8)	36	26.3 (4.4)		Response**	**N (%)**	**N (%)**	**N (%)**	**N (%)**
	Post: Week 12	21	11.0 (7.9)	27	18.2 (7.8)	*d* = - 1.195	1	12 (41)	5 (14)	8 (27.5)	9 (25)
	Mean difference		13.6		8.1		2	6 (21)	10 (28)		
							>2	11 (38)	21 (58)		
							Mean Y-BOCS	**M (SD)**	**M (SD)**		
							gp reduction	55.3% (NR)	30.8% (NR)		
Foa et al. (2005)		**iERP**		**Placebo (P)**				**iERP**	**P**	**iERP**	**P**
iERP vs P	**Time point**	**N**	**Mean (SD)**	**N**	**Mean (SD)**	**Effect size**		**Clinically Significant Change**		**Drop Out**	
	Pre: Week 0	29	24.6 (4.8)	26	25.0 (4.0)		Response**	**N (%)**	**N (%)**	**N (%)**	**N (%)**
	Post: Week 12	21	11.0 (7.9)	20	22.2 (6.4)	*d* = - 2.42	1	12 (41)	0 (0)	8 (27.5)	6 (23.1)
	Mean difference		13.6		2.8		2	6 (21)	2 (8)		
							>2	11 (38)	24 (92)		
							Mean Y-BOCS	**M (SD)**	**M (SD)**		
							gp reduction	55.3% (NR)	11.2% (NR)		

*Moody et al., (2017) reports combined number of final OCD participants treated, thus combining the 21 participants who comprised the wait list control group for 4 weeks before receiving CBT/ERP.

**Response is defined by a rating of 2< improvement on the Clinical Global Impression Scale, data reported is for 'treated' participants as opposed to 'completer' participants.

C: Clomipramine; gp: group; iCBT: Intensive Cognitive Behavioural Therapy; iERP: Intensive Exposure and Response Prevention; P: Placebo; *SD*: standard deviation; Y-BOCS: Yale Brown Obsessive Compulsive Scale.

APPENDIX A

Method

Search Methods for Identification of Studies

Search strategy.

The terms used were: obsessive-compulsive disorder" OR "obsessive-compulsive" OR "OCD" OR "obsess*" in combination with "cognitive Behav* therapy" OR "cognitive therapy" OR "Behav* therapy" OR "ERP" OR "exposure and response prevention" OR "exposure and ritual prevention" AND "RCT" OR "random*" OR "randomized controlled trial".

Data Collection and Analysis

Selection of studies.

The first author conducted the literature search, all references were initially imported to Endnote referencing manager software and then transferred to Covidence systematic review software (www.covidence.org). All articles were evaluated according to the inclusion criteria outlined above.

Review authors were not blinded to the study details (i.e. names of authors, journal of publication etc.) when they applied the inclusion criteria.

Data extraction and management.

A data extraction sheet was developed based on the Cochrane Consumers and Communication Review Groups' data extraction template (Cochrane, 2016).

Assessment of risk of bias in included studies.

JM and AB independently rated each study using The Cochrane Collaboration's tool for assessing risk of bias in randomised trials (Higgins et al., 2011). The two review authors were not blinded to the names of the authors, institutions, journal of publication or results of the studies. The authors of the studies were contacted for further information where necessary.

Application of the Cochrane risk of bias tool to the included studies.

Selection bias.

Random sequence generation: We checked for possible selection bias by assessing the method used to generate the allocation sequence. Low risk was categorised by the use of

any method which employed a truly random process (e.g. computer-generated random number or use of a random number table). High risk was deemed as methods that are not truly random (e.g. every alternating patient is allocated to the control arm). Unclear was specified if there was insufficient information about the random component of the sequence generation process.

Allocation concealment: The possibility of selection bias was also assessed by examining the method used to conceal allocation sequence to trial arm prior to the time of assignment. Low risk included methods such as central randomisation (remote site from trial location), sealed opaque envelopes etc. High risk included methods that cannot be adequately concealed such as case record numbers, non-opaque envelopes. Unclear was if the method used was not adequately described or the study did not address this outcome.

Performance bias.

Blinding of participants and personnel: We assessed the risk of possible affect of knowledge of which intervention is provided/ received on outcome (rather than the effect of the intervention itself) by examining blinding during the study.

It is generally not possible to blind psychological therapists to which therapy they are providing. It is also difficult to blind participants to which psychological treatment they are receiving due to prior knowledge and comparisons they can make (with other treatments they know about or have heard of) during the study. However, risk of bias from "differential expectations" can be considered by evaluating participants' and therapists' pre-treatment expectations and enthusiasm for treatment, respectively (Munder & Barth, 2018). When two treatments are being compared perceived credibility of the respective treatments should be assessed (Öst et al., 2015).

Low risk was deemed if blinding was not possible due to the design of the study but differential expectations and credibility ratings were measured prior to participant's commencement of the trial (Munder & Barth, 2018). High risk was specified where blinding was possible but was not used or was incomplete or it was likely that it could have been broken and participant's perceived credibility of comparable treatments was not assessed. Unclear was when the study did not address the outcome or insufficient information was available to permit judgement.

Detection bias.

Blinding of outcome assessors: We checked for detection bias by assessing the methods used to blind outcome assessors from knowing which arm of the trial a participant had been in when conducting the outcome assessment. Low risk was deemed when the study described the method used to blind assessors and it was unlikely that the blinding could have been broken. High risk was deemed when blinding was not used (e.g. the same therapist delivered treatment and outcome assessment) or blinding was used but could likely be broken. An unclear risk of bias was deemed when a study specified that blinding had been used, but it was not adequately described, or insufficient information was available to permit judgement.

Attrition bias.

Incomplete outcome data: We checked for the possibility of attrition bias between study arms by assessing the methods used to manage missing/ incomplete data. A dropout rate of one in five is cited as common is psychotherapy trials (Swift & Greenberg, 2012) and is reflected in health service research (Olfson et al., 2009; Wells et al., 2013). Low risk was deemed as < 20% attrition or the use of intention to treat analysis or if the reason for missing outcome data was unlikely to be related to true outcome. High risk was deemed if only the data of participants who completed the study was used in the analysis or attrition was > 20% or if attrition was unbalanced in numbers across intervention groups. Unclear risk was deemed if there was inadequate reporting or the study did not address this outcome.

Reporting bias.

Selective reporting: We checked for the risk of within study publication bias by assessing if all predetermined outcomes were reported. Low risk was deemed when all outcomes were reported as specified by protocol or trial register if available, or all outcomes listed in methods are reported in results. High risk was determined to be when one or more outcomes were not reported as per protocol/trial register/methods section. Unclear risk was deemed when inadequate information was provided.

Other sources of bias: Importance of treatment implementation.

Psychotherapy interventions are described as ‘complex’ interventions because they are comprised of several interconnecting components (Campbell et al., 2007). Due to the various active components of ‘complex’ interventions, checks of treatment implementation (i.e. treatment integrity, therapist adherence and competence, training, supervision, and the

number of therapists providing a treatment within a trial) are important (Munder & Barth, 2018).

Treating therapist Factors: We assessed for risk of treatment implementation bias by examining therapist qualifications, training, supervision and number of therapists delivering interventions within a trial. Differences in the professional backgrounds of CBT therapists have been shown to affect levels of competence and varying requirements post-core training to attain CBT competence. Liness et al. (2019) reported that clinical psychologists required less support to achieve CBT competence than therapists without a core profession. If an RCT employs only one therapist to provide the intervention, the likelihood of confounding between the therapist and therapy method is high, making it difficult to credit specific outcome to the therapy utilised (Öst et al., 2015). If a single therapist provides both compared therapies, the therapist factor is somewhat controlled, provided that competence and adherence measures are undertaken for both treatments (Öst et al., 2015). Low risk was deemed if the therapist qualification was stated and/or appropriate training, experience and supervision were detailed, and more than one therapist provided the intervention or adherence and competence ratings were provided for sole therapists or if the comparison intervention was an active psychotherapy control. High risk was deemed if the therapist had not been trained, supervised or was the sole therapist providing the intervention and adherence and competence ratings were not undertaken. Unclear risk was deemed if there was inadequate reporting or the study did not address this outcome.

Treatment Fidelity: We assessed for risks to treatment fidelity by assessing therapist adherence and competence. Therapist adherence refers to the extent to which the therapy delivered, is the same as that prescribed by a treatment manual or conforms to/ includes specific procedures that are specific to a particular form of CBT (Ginzburg et al., 2012). Therapist competence refers to the "extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" (Fairburn & Cooper, 2011, p. 374). Within psychotherapy trials this is ordinarily assessed by audio- or video-taping of therapy sessions, which are then rated on a standardised measure (e.g. Cognitive Therapy Scale-Revised (CTS-R); Blackburn, James, Milne & Reichelt, 2001). Low risk was deemed if treatment fidelity was addressed (i.e., therapy sessions recorded and rated). High risk was deemed if treatment fidelity was not assessed. Unclear risk was deemed if there was inadequate reporting or the study did not address this outcome.

Results

Participant Characteristics

Symptom and demographic information.

All studies specified that participants meet diagnostic criteria for OCD according to DSM-III-R (APA, 1987) or DSM-IV (APA, 1994). Two of the studies required a minimum Y-BOCS score of ≥16 (Foa et al., 2005; Moody et al., 2017), one study required illness duration of at least one year (Foa et al., 2005) and one required age of OCD onset before age 18 (Moody et al., 2017). One study focused specifically on postpartum OCD and thus included only women with a baby of less than 6 months in age (Challacombe et al., 2017).

Only two studies reported the mean age of OCD onset. Foa et al., (2005) reported mean age of 18 years with a mean duration of illness of 16.4 years. Challacombe et al., (2017) study of postnatal OCD had a mean age of onset of 26.82 years with 35% of the sample developing OCD in relation to the current birth. Lindsay et al. (1997) reported a mean duration of 11 years. However, it should be noted that across studies when the beginning of this time period is deemed to be (i.e. age of first occurrence of OCD symptoms or age at which OCD first caused significant interference or age of OCD diagnosis) is unclear.

Participants' use of concurrent pharmaceutical interventions for OCD whilst undertaking the trial was reported by all studies. Three studies permitted concurrent pharmaceutical use that was not prescribed as a part of a trial arm. Within these studies the proportion of pharmaceutical interventions ranged from 14% to 50% with a mean of 24%.

Inclusion criteria.

All studies specified that participants meet diagnostic criteria for OCD according to DSM-III-R (APA, 1987) or DSM-IV (APA, 1994). One study did not specify any further inclusion criteria (Lindsay et al., 1997). Two of the studies required a minimum Y-BOCS score of ≥16 (Foa et al., 2005; Moody et al., 2017), one study required illness duration of at least one year (Foa et al., 2005) and one required age of OCD onset before age 18 (Moody et al., 2017). One study focused specifically on postpartum OCD and thus included only women with a baby of less than 6 months in age (Challacombe et al., 2017).

Assessment of Participants for recruitment.

In three studies the inclusion/ exclusion criteria were applied via a clinical interview with a qualified clinician and diagnosis was confirmed via a standardised semi-structured

interview measure e.g. SCID (*n* = 2), ADIS-IV Mini (*n* = 1). The fourth study did not provide information on the method used for assessment and diagnosis (Lindsay et al., 1997). Only one study (Moody et al., 2017) provided information on inter-rater reliability. Foa et al. (2005) reported that interrater reliability had not been assessed whilst this was absent from the reports of the other two studies.

Exclusion criteria.

Only one study did not specify exclusion criteria (Lindsay et al., 1997). The other three studies excluded participants if OCD was not their primary problem or if Psychosis, Bipolar disorder or substance abuse was present. Moody et al. (2017) further excluded participants with Attention-deficit hyperactivity disorder (ADHD) and those who made changes to SSRI medications within the 12 weeks prior to trial enrolment. Foa et al. (2005) applied the exclusion of adequate clomipramine treatment and significant Electrocardiogram abnormalities. Challacombe et al. (2017) excluded those refusing to be videotaped and those with twins.

Results of the Risk of Bias Assessment

Allocation

Sequence generation.

All studies specified that they randomly allocated participants to conditions. However, only one study (Challacombe et al., 2017) specified the sequence generation method (i.e. computerised randomisation) and was therefore rated ‘low’ risk of bias. The remaining three studies were rated ‘unclear’.

Allocation concealment.

Three studies reported preliminary analysis on demographics and symptom severity to assess the comparability of the groups, for which there were no concerning pre-treatment differences between groups likely to affect outcome (Challacombe et al., 2017; Foa et al., 2005; Lindsay et al., 1997). However, only one study specified method of allocation concealment, detailing that sealed opaque envelopes were used and opened at the end of baseline assessment (Challacombe et al., 2017) and was rated as ‘low’ risk. The remaining three studies were rated as ‘unclear’.

Blinding

Performance bias.

Only one study reported on the blinding of personnel within the study (Foa et al., 2005) and was rated 'low' risk. However, this was the only study that employed a pharmacological intervention study arm and the blinding pertained to knowledge of this throughout the trial. No studies reported on attempts to assess participants' pre-randomisation treatment expectations/ preferences or credibility of compared interventions. Lindsay et al. (1997) reported participants' post-treatment ratings of therapists' 'supportiveness and understanding' in an attempt to guard against therapist variables impacting on outcome, however the validity of this measure for this construct is unclear. Lindsay et al. (1997) used an active comparator (Anxiety management) however no credibility or expectation ratings from patients are provided, and thus was deemed 'high' risk. Two studies employed waitlist control or TaU where participants in these conditions accessed the intervention treatment post trial. This design could affect the natural course of recovery in a potentially negative (e.g. recovery is on hold until…) or positive (e.g. anticipated rescue of treatment) direction (Price, Mitchell, Tidy, & Hunot, 2008). However, OCD is well known to be chronic without appropriate treatment (Öst et al., 2015), the risk of bias was deemed to be 'low' (Challacombe et al., 2017; Moody et al., 2017).

Detection Bias.

Two studies reported that blind independent evaluators conducted the outcome assessments (Challacombe et al., 2017; Foa et al., 2005). . However, only one specified that the assessors were external to the study (Challacombe et al., 2017). Thus Challacombe et al. (2017) was rated as 'low' risk and Foa et al. (2005) was rated as 'unclear'. Lindsay et al. (1997) and Moody et al. (2017) did not directly report on their outcome assessors and thus were rated as 'unclear' risk.

Incomplete Outcome Data

Two studies reported no attrition (Lindsay et al., 1997) or less than < 20% and utilised intention to treat analysis (Challacombe et al., 2017) and were rated as 'low' risk of bias. Moody et al. (2017) reported < 20%, and was rated 'low' risk, although only completer data was used in the analysis. Foa et al. (2015) reported a dropout rate of 29% with no differences across conditions and with similar reasons reported for dropout across the groups and was rated 'low' risk of bias. Foa et al. (2005) reported that data had not been collected on patients

who dropped out of treatment after randomization but before treatment, thus could not be included in last-observation-carried-forward analyses.

Selective Reporting

The study protocol was available for only one study (Moody et al., 2017), however all studies reported on outcomes listed in their methods sections and were all deemed 'low' risk of bias.

Other Potential Sources of Bias: Importance of Treatment Implementation

Treating therapist factors.

Only one study stated the profession of the therapist (Lindsay et al., 1997) whilst the remaining reported that qualified/ registered therapist delivered the intervention and were either specialised at treating OCD or details of the training received was specified. Only two of the studies specified that therapists received clinical supervision throughout the trial (Challacombe et al., 2017; Foa et al., 2005). All studies reported using more than one therapist, however the one trial that used an active psychotherapy comparator did not provide adherence and/or competence ratings and thus was rated as 'high' risk. All other three studies were deemed 'low' risk.

Treatment fidelity.

Three studies utilised manualised based CBT and two reported details of how quality assurance and adherence to the manual were monitored during the trial (Foa, et al., 2005; Moody, et al., 2017). However, only Moody et al. (2017) reported the average of both quality of sessions and treatment adherence and was rated 'low' risk. Lindsay et al., (1994) reported that treatment integrity was maintained but did not provide specific details of how this was done in practice (Lindsay et al., 1997) and was rated 'unclear' risk. Challacombe et al. (2017) did not provide details of treatment fidelity and was rated as 'unclear' risk.

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CHAPTER 5

METHODS AND METHODOLOGY

Chapter Rationale

This chapter will provide an outline of the approach taken in the primary research presented in this thesis. Full details of the methods used in each of the six studies are provided within the respective manuscripts. Thus, the aim of this chapter is to provide a broader perspective with regards to the overarching theoretical and epistemological framework that has been used to inform the research decisions made. This chapter will also afford the opportunity for the position of the researcher to be outlined with respect to the qualitative methods chosen. In the chapters that follow, due to the alternative format of this thesis and the predetermined word count restrictions of journals, details germane to the author's epistemological and ontological stance have been minimised in order to prioritise other aspects of the manuscript. However, the author acknowledges that the transparency of these details is important and integral to the research itself and thus they are outlined in this chapter.

CHAPTER 5

METHODS AND METHODOLOGY

"Psychology ought to take the lead in exploring the relationship between science and the humanities - a matter not of altruism or imperialism but of necessity dictated by its subject matter" (Koch, 1961 as summarised by Smith, 2001, p. 441).

Overview of Research Position

As a clinical psychologist undertaking research, my aim is to conduct research that will be clinically important and applied. The origins of the research questions addressed in this thesis have been developed through my stance as a scientist-practitioner, drawing on the cognitive behavioural theory of OCD (Salkovskis, 1985, 1999) as well as experiential learning theory (Kolb, 1984). I have adopted a critical realist perspective and applied this when approaching the analysis and interpretation of the findings from my studies. I have used the model of empirically grounded interventions (and underpinning theory) as a compass to contemplate the direction taken in successive studies in this thesis. I have depicted my theoretical framework in Figure 1. The following sections will examine each aspect of this framework to describe how I came to this research position.

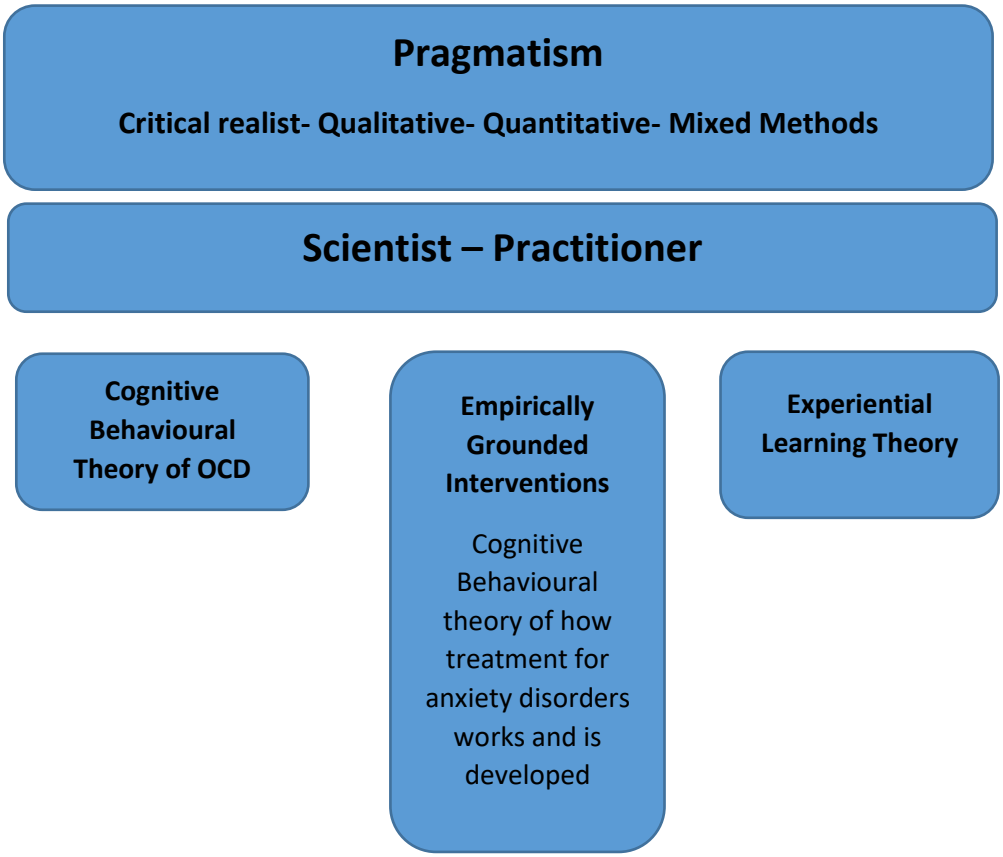

Figure 1. Theoretical framework underpinning my approach

Locating My Research Position

In order to locate myself in a position that is both useful and relevant, it is imperative to have a working knowledge of the development and evolution of the methods central to the field of clinical psychology. I will briefly outline these below in relation to how they have informed my research position.

Empirically Grounded Interventions – Cognitive Behavioural Theory of OCD

The 'traditional science period' (which dominated the 19th and early 20th century) employs a positivist epistemology; that is the premise that there is a set of beliefs with regards to how 'legitimate' or 'true' knowledge can be obtained (Rogers & Willig, 2017). Adopting the scientific method of hypotheses testing, utilising quantitative methods (e.g. controlled experimental or quasi-experimental study designs) has led to the development of cognitive-behavioural approaches, which is the evidence-based treatment approach that I apply as a therapist in clinical practice for OCD. Salkovskis (2002) eloquently articulated the model of 'clinical science' that underpins the cognitive behavioural understanding and consequent treatment of psychological problems. Salkovskis (2002) describes CBT as a

series of interventions that are empirically grounded and implemented by therapists who function as scientist-practitioners. As illustrated in Figure 1, it is through a sequence of methodical and interconnected factors that CBT was developed, and this process enables refinement to the model to be continuously made.

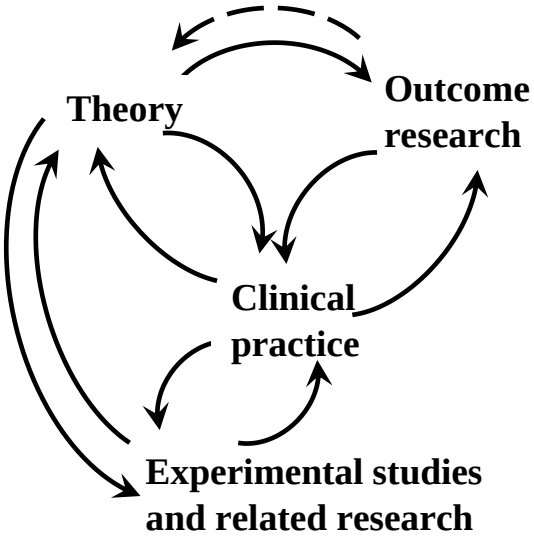

Figure 2. The process required for the development of empirically grounded clinical interventions.

Scientist - Practitioner

Up until the point of commencing my PhD studies, my background (academic and clinical training) had been limited purely to a scientific/ positivist approach. In my clinical work I was particularly passionate about adopting the scientist-practitioner model (Hayes, Barlow, Nelson, & Rosemery, 1999; Shapiro, 1961). This model promotes the use of empirical findings to be applied in clinical practice (as illustrated above in Figure 2). From a clinically applied perspective this model provides the assurance that as a therapist you are offering up to date treatments with proven efficacy based on empirical research. Also, of clinical significance is the second aspect central to the role of a scientist-practitioner, which is the use of experiences gained in clinical practice to inform future research questions.

During my clinical training and in my first role post qualification, I was assigned patients with a diagnosis of OCD. Many of these patients had previously received one or more courses of CBT but had not responded optimally and remained significantly disabled by their symptoms. I was hugely disappointed by the significant shortcomings of evidence-based treatment and believed strongly that this needed to be addressed. One particularly key clinical experience occurred when I was 25 years of age and I had been assigned a patient who was 24 years old. This patient was significantly disabled by her OCD, predominantly

house bound and spent most of her waking hours engaged in washing and checking rituals. It struck me that despite our similarities in age, our past and present experiences in life were vastly different. The patient's OCD had robbed her of many years of schooling, she was socially isolated and predominantly nocturnal. I noticed that for this patient and others who were particularly disabled/ housebound the one-hour weekly therapy session seemed to provide barely enough time to get started before it had come to an end. This first-hand experience of therapy falling short delivered in this format motivated me to consider alternatives.

Experiential Learning Theory

I became interested in the idea of delivering CBT more intensively. I was curious as to whether an extended session time would facilitate greater opportunities for the patient to try out the exposure tasks in-session and discover how they work with the support of myself there as the therapist. This idea was underpinned by Kolb and Lewin's (Kolb, 1984) theory of experiential learning (Figure 3). Specifically, it was hypothesised that an intensive version would provide the time in therapy and the opportunity for the patient to repetitively experience the different elements of the cycle. The continual experience of moving through the experiential learning cycle would allow the patient to grasp these experiences and transform them in to knowledge.

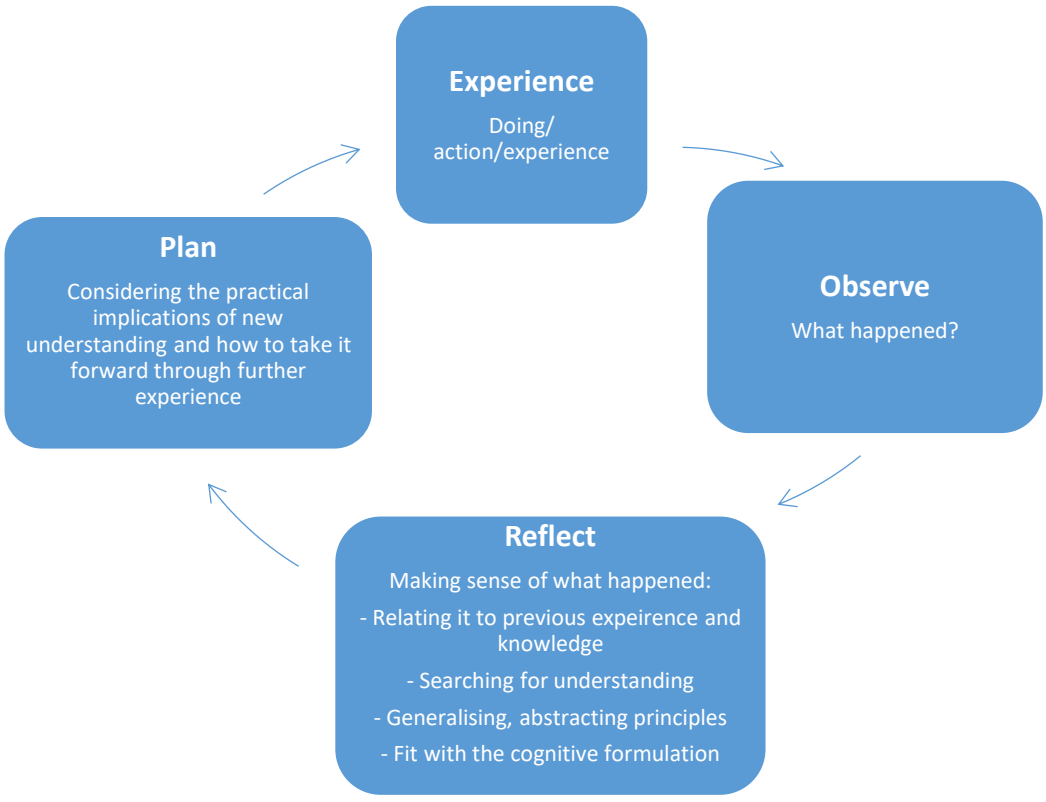

Figure 3. The cycle of Experiential Learning

Overall, I became interested in trying to understand what could be done differently in therapy to cultivate a more positive outcome for this patient. I was also interested in trying to understand what the experience of these treatments that had failed to help from the perspective of the patient. It was from here that my journey of inquiry into such questions began and the outcomes of this inquiry form the basis of this thesis.

Qualitative Methods

Through this process of inquiry, I discovered that some of the questions I had generated did not lend themselves exclusively to quantitative methods. It has been said that psychological research should investigate "humanly significant problems with methods chosen or devised with intelligent flexibility for the problems being pursued" (Smith, 2001. p. 443). I thus began to explore alternative methods, discovering qualitative frameworks and mixed methods options. Qualitative methods have been applied in psychology since the late 19th century, when the use of the scientific method and its aligned assumptions were scrutinised in relation to their appropriateness for examining psychological phenomena (Smith & Heshusius, 1986). In contrast to the study of individual phenomena using quantitative criteria (e.g. reliability, validity), the qualitative field employs a vastly different set of approaches and beliefs with respect to epistemology, ethics and politics. These factors are therefore important to consider when utilising this methodology.

Mixed Methods

The third period of methodological movement, which incorporated the idea of combining both qualitative and quantitative methods (now known as 'mixed methods research'), took place in the 1960s. Although quantitative methods have remained dominant in the field of clinical psychology, from an applied perspective the use of mixed methods is appealing, as it allows the flexibility required for the research question to be the deciding factor for determining which method is used (Howe, 1988). Mixed methods are defined as "research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry" (Tashakkori & Creswell, 2007, p. 4).

Some scholars have argued that in order to gain a full understanding of humans, it is not only useful but indeed necessary for psychologists to use both qualitative and quantitative methods (Yardley & Bishop, 2017). This is true for many of the scientists who have been most influential in the field of clinical psychology. They have all began as

exceptional phenomenologists who listened to their patients as the starting point of their research endeavours, which culminated in experimental designs (Salkovskis, 2002).

Despite arguments relating to the research benefits of the mixed methods approach, the paradigms, aims and assumptions connected with qualitative and quantitative research are distinct and appear to clash. The 'incompatibility thesis' postulates that the methods are incompatible due to the conflicting epistemologies of the two approaches (Tashakkori & Teddlie, 2003). In contrast to quantitative methods, qualitative research is generally underpinned by 'interpretive' or 'constructionist' perspectives and the assumption that there is no 'single truth' (Yardley & Bishop, 2017). In the current thesis, a mixed methods approach allowed qualitative explorations of poorly understood phenomena to be further developed by quantitative research, which allowed the generalisability of qualitative findings to be examined and hypothesis testing to be carried out. Nonetheless, the clashing of the underpinnings of these methods made me aware that if I wished to utilise both methods, careful consideration of the respective aims and assumptions was paramount. A theoretical framework that bridges these methods was also required.

Overarching theoretical framework: Pragmatism

Pragmatic theory is useful for helping to deconstruct the differences between quantitative and qualitative paradigms and offers a framework for embracing and combining both methods of inquiry (Tashakkori & Teddlie, 2010). From a pragmatic perspective the aim of research is to gain an improved and richer understanding of the phenomena under investigation, whether this be through a single or combined methods approach (Maxcy, 2003). One of the founders of pragmatism, John Dewey proposed that "common-sense, scientific and moral judgements are all based on knowing what things are good for and what changes need to be made" (Hickman & Alexander, 1998, p. 129). Under this premise knowledge is inherently linked to intentions and actions and meaning is extracted from our evaluation of the effects of these actions (Hickman & Alexander, 1998) .

Pragmatism provides a functional definition of knowledge and truth. Rather than aspiring to a universal or objective truth, truth is defined in relation to a specific goal within a specific context (Yardly & Bishop, 2017). This means that all actions (methods) are evaluated as 'correct'/ 'right' based on the degree to which they meet their goals. The evaluation of the action as 'correct'/ 'right' must be based on the test of 'external consequences' (Yardly & Bishop, 2017). The most relevant consequences and the most appropriate method of evaluation will differ according to the type of knowledge/ action in question (Yardly & Bishop, 2017). For example, knowledge/ actions intended to determine

if intensive CBT is more effective than weekly CBT for OCD should be evaluated by their respective effects on patient outcome and decrease in symptom severity. Therefore, a randomised controlled trial would provide the precision required for establishing efficacy of such interventions. If the knowledge/ actions intended are to understand the acceptability and experience of intensive CBT, then qualitative interviews would be well suited.

The methods of inquiry and appropriate forms of validation for qualitative and quantitative approaches are different and specific. For example, I have learnt that one of the potential perils in attempting to undertake qualitative research, (with a background in quantitative methods) is that you can, by default, transport your epistemological stance to this work. You are then at risk of inadvertently failing to consider available alternatives and transposing inappropriate or irrelevant criteria. For example, I initially thought that it would be useful to denote the number of participants from which I had taken data to create themes or subtheme in thematic analysis. This is a clear example of attempting to quantify qualitative data, which is not theoretically warranted.

However, what is shared between both methods is the commitment to conducting research both rigorously and conscientiously, to linking theory and empirical findings, as well as to critiquing and disseminating the outcomes of the research (Sale, Lohfeld, & Brazil, 2002). While the criteria for making the decision are different, both methods also require an appropriate sample size, to seek either generalisability or transferability to others with the characteristics under investigation (Malterud, 2001). In addition, both methods require deliberation regarding how best to analyse and represent the data and to ensure the narrative is coherent. Of greatest shared importance is the contribution towards advancing theoretical understanding or practical impact (Yardley, 2000, 2007). The bottom line, from a pragmatic standpoint is that the key objectives of both approaches in terms of methodological rigour is shared.

The use of mixed methods in this thesis

When utilising mixed methods, the reasons for doing so and the aims of each should be clear. It should also be clear whether priority is being given to the qualitative or quantitative component of the research. In this thesis, this specific information is detailed in the rationale/ introduction which precedes each empirical study. Moreover, within this thesis the outcome of each study has informed the design of the subsequent studies within the thesis. For example, the qualitative and mixed method findings from Study 2, 3 and 4 informed the development of the questionnaire that was utilised in Study 5. Using a mixed

methods approach enabled the flexibility required to produce complementary findings, to provide a more rounded understanding of the questions in focus.

The use of 'triangulation' (utilising a combination of methods to study the same phenomena) in mixed methods is often cited, under the guise of serving to validate or verify results across different methods (Tashakkori & Teddlie, 2003). It has been suggested that a mixed methods approach aids the internal and external validity of the result. However, agreement across the results of both qualitative and quantitative findings is not necessarily a measure of the validity of the results (Mertens & Hesse-Biber, 2012). The alternative to this view is that the aim of triangulation is to gain a more in-depth and nuanced understanding of the topic of interest (Mertens & Hesse-Biber, 2012). This is consistent with the view that both methods can be used to complement and thus supplement each other (Erzberger & Kelle, 2003). The use of mixed methods in this thesis aims to increase the depth of scope and understanding by utilising different methods.

In qualitative research it is important that the paradigms that are being used are made explicit (Yardley & Bishop, 2017). As such, the next section of this chapter provides a more detailed outline of my theoretical position within the thematic analysis framework, which is utilised as the dominant method in Study 2, 3 and 6.

Thematic Analysis

The approach to thematic analysis (TA) that I have employed is that described by Braun and Clarke (2006, 2013). This specific approach was selected as it is independent from any specific epistemological and ontological foundation. This theoretical independence, and associated flexibility, is one of the key aspects that makes this approach distinct from other TA and other qualitative approaches (Braun & Clarke, 2013).

Within the TA method, my ontological approach is one of a critical realist. This orientation aims to identify prevailing patterns of meaning within the data and seeks to understand language as creating reality, rather than being a reflection of it (Terry, Hayfield, Clarke, & Braun, 2017).

Application of Theoretical Stance

I employed an inductive approach to coding; this means that I approached the data from a 'bottom up' perspective. I used the data as a starting point for identifying meaning that was cohesive and shared across the data. I interpreted this patterned meaning to identify codes and subsequently develop themes. I am aware that the subjectivity of the researcher is an integral part of the analysis. It is impossible to create a blank slate from which to approach

the data, thus I acknowledge that the lens from which I viewed the data is not purely objective. However, the inductive approach signals that the analysis was data-led (Terry et al., 2017). I viewed my role in the analysis as an active process in which I was responsible for identifying and interpreting patterns and meaning. With this responsibility, I acknowledge that there are several processes at play that affect the way that I identified and interpreted the data and that these factors come together and intersect with the data. This will be elaborated on further in the discussion of reflexivity.

Coding develops depth with repeated engagement with the data, and therefore immersion in the data is required (Braun & Clarke, 2013). I achieved this through conducting the interviews myself, transcription of some of the interviews, followed by reading all interview transcripts at least three times each. During the second reading of the transcripts I annotated them with initial thoughts. This process was followed by an extended and detailed process of coding. I identified a combination of both semantic and latent codes. Semantic codes were more descriptive and provided summaries of the data where appropriate. I used latent codes when identifying underlying meaning and patterns within the data. Following the phases outlined by Braun and Clarke (2006, 2013), which have a strong emphasis on familiarising oneself with and truly engaging with the data, helped to provide the assurances of quality and rigour. In the writing of Studies 2, 3 and 6 I used extracts from the data illustratively, presenting them as key elements of evidence to support the analytic narrative (Terry et al., 2017).

Reflexivity

Due to the mediating role of the researcher in the analysis and interpretation of the data (as described above), the principles and practice of reflexivity are essential (Rogers & Willig, 2017). To ensure these factors were at the forefront of my mind, myself and the second coder (involved in Studies 3 and 6) completed a reflexive outline (Appendix A). This involved thinking about the various ways our 'position' in society impacts the way in which we as individuals observe and perceive others in our daily lives. It involved thinking about the 'values 'or 'biases', that we may bring to and/or impose on the research. Thus, we considered our socio-demographic positioning (e.g. marginality/ privilege, age, sex, gender, ability etc.), our personal background and life experiences, our research training, research experiences and discipline specific knowledge, political framework, our theoretical and methodical assumptions, and our personal experiences of working with people who have OCD. We completed the reflexive outlines individually and then discussed these collaboratively throughout the research process. Factors identified through this process were

reflected on and discussed in supervision when relevant to discussing the findings of the studies. In such discussions this influence was acknowledged, and different perspectives were discussed.

Summary of Approach

In summary, I have applied an overarching pragmatic framework to the research I have conducted. Within this framework the research questions posed have guided my choice of method and I have been sensitive in ensuring the appropriate forms of validation and rigour applied to the respective method. At heart, I am a clinical psychologist who is dedicated to drawing on rigorously conducted research to inform my clinical practice, in order to provide the most up to date and evidence-based treatment available.

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CHAPTER 6: STUDY 2

When Cognitive Behavioural Therapy for Obsessive Compulsive Disorder Fails: Service User Perspectives

Chapter Rationale

As detailed in the introduction to this thesis a large proportion of service users do not respond optimally to standard CBT. Current explanations for treatment failure are predominantly from the perspective of the therapist. In this study we employed a mixed method design to investigate service users' perspectives on the reasons their previous treatment had been unsuccessful. To provide a context, we obtained descriptive information to determine whether participants reported previous CBT to be of adequate quality, and therefore establish whether treatment failures in the sample could be explained by technical failures due to inadequate provision of CBT. Qualitative interviews were then utilised to gain an in-depth insight into participant views of treatment failure. The use of qualitative methods to explore the details of variability in people's experiences (which is excluded from quantitative research in order to achieve reliability) is particularly valuable in gaining a more in-depth view in the factors involved in treatment failure (Yardley & Bishop, 2017).

This declaration concerns the article entitled:			
When Cognitive Behavioural Therapy for Obsessive Compulsive Disorder Fails: Service User Perspectives.			
Publication status (tick one) **Draft manuscript** [x] **Submitted** [ ] **In review** [ ] **Accepted** [ ] **Published** [ ]			
Publication details (reference)	Millar, J.F.A, Salkovskis, P.M., Gregory, J. & Halligan, S. L.		
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Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.		
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When Cognitive Behavioural Therapy for Obsessive Compulsive Disorder Fails: Service User Perspectives

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Abstract

Background: Cognitive Behavioural Therapy (CBT) is an effective psychological treatment for Obsessive Compulsive Disorder (OCD), but not all service users' benefit from treatment. The factors involved in non-optimal response have been largely examined from the perspective of therapists. The current study explored the reasons for treatment failure from the perspective of service users with 'treatment resistant' difficulties.

Method: Twelve participants were recruited, six with OCD and six with Panic Disorder (PD), with the latter being included as a comparison group. All participants had undertaken $\geq$ 2 unsuccessful courses of CBT. The Treatment History Questionnaire (THQ) was used to determine the adequacy of participants' previous treatment. Qualitative interviews were conducted, and thematic analysis was used to analyse interview data.

Results: The THQ indicated that most participants had undertaken a technically adequate previous course of CBT, meaning that inadequate therapy was unlikely to be the sole reason for treatment failure in the study sample. The qualitative findings indicated three overarching themes capturing participants' experiences of treatment and its failure: 1) Invalidating and Disempowering Experiences; 2) Factors Relevant to Formulation and Socialisation; and 3) Wider Barriers to Recovery. The first two themes were shared by both OCD and PD participants and the third was specific to OCD.

Conclusion: The majority of factors underpinning therapy failure related to the therapeutic interaction and were pertinent to both participants with OCD and PD. In addition, OCD participants described a wider set of socio-contextual obstacles to their benefitting from treatment. Clinical implications are discussed.

Key words: Obsessive Compulsive Disorder, OCD, Cognitive Behavioural Therapy, CBT, Treatment failure

Introduction

Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) is the psychological treatment of choice for Obsessive Compulsive Disorder (OCD) (Katzman et al., 2014; Koran & Simpson, 2013; NICE, 2005, 2018). It has a robust evidence-base, and has been shown to be efficacious in both randomised control and pragmatic trials (Öst et al., 2015). Nonetheless, of those who receive this intervention, only 40-52% experience full remission (Farris, McLean, Van Meter, Simpson, & Foa, 2013). Potential reasons for this have been cited to include finding it too difficult to fully engage with CBT, or discontinuation before therapeutic gains have been made (Abramowitz, 2006; Eddy, Dutra, Bradley, & Westen, 2005; Whittal, Robichaud, Thordarson, & McLean, 2008).

For service users who have been offered CBT, but have found it unacceptable or of minimal benefit, it is important to investigate the reasons for this. Rachman (1983) proposed a framework for examining treatment non-response that comprised two categories of explanation: 'serious treatment failures' and 'technical treatment failures'. Serious treatment failures refer to instances in which the service user fails to respond despite the treatment and its delivery being at least 'adequate' (Rachman, 1983); whereas technical treatment failures are instances in which the service user fails to respond because the treatment is fundamentally inadequate or the therapist does not adequately deliver the treatment (Rachman, 1983). For example, the therapist may claim they are offering CBT, but in practice the therapy may not include key therapeutic components (e.g. they may not accompany the service user to contexts where symptoms are prominent, as required to support and generalise the effects of ERP).

When exploring reasons for 'serious treatment failures', patient characteristics have been examined as predictors of non-optimal response. Characteristics identified include comorbidity, particularly in the form of severe concurrent depression, as well as reduced insight or overvalued ideation (Foa, 1979; Foa et al., 1999; Steketee, Chambless, & Tran, 2001; Veale, 2002). Symptom severity and type of OCD symptoms have been shown to predict poorer treatment response in some studies; however, in other studies this has not been evidenced (Lomax et al., 2009; Mataix-Cols, Marks, Greist, Kobak, & Baer, 2002). VanDyke and Pollard (2005) suggest that the presence of 'treatment interfering behaviours' (TIB) may be associated with non-optimal response. Pollard (2006) defines TIBs as "any behaviour the therapist believes is incompatible with effective participation in therapy or the pursuit of recovery" (Pollard, 2006, p 62). Pollard (2006) suggests that patients' readiness for therapy should be addressed, which may include working with the patient on any beliefs that may not be conducive to working collaboratively in therapy, on identified 'skills

deficits' or 'emotional dysregulation', or on difficulties with 'incentive or motivation' (Pollard, 2006). However, almost by definition, sufferers may exhibit many TIBs at the start of therapy. It is therefore important that this formulation does not result in transferring responsibility for treatment failures to patients.

Determining the proportion of patients who fall into technical treatment failures is challenging in the context of psychological interventions, where a clear definition of what constitutes an 'adequate' version and 'adequate' delivery of treatment is not widely available or agreed upon. Stobie (2009) conducted a study with the aim of establishing a benchmark regarding the specific techniques that should be included in 'adequate' CBT for OCD. A panel of expert researchers and clinicians identified 19 aspects of therapy that should be included for CBT for OCD to be considered adequate. The study also identified 16 techniques that would not constitute CBT for OCD. The results of this study, in combination with the National Institute for Health and Care Excellence (NICE) (2005) guidance, provide a helpful benchmark for what constitutes adequate CBT for OCD. In light of this benchmark, research conducted at a specialist OCD treatment service in the UK found that only 16% of patients defined by referring services as 'treatment refractory' had been offered a technically adequate treatment when they first sought treatment for OCD (Stobie et al., 2007). This suggests that a substantial proportion of OCD treatment failures may fall into the 'technical failure' category.

To date, the research on non-optimal response to therapy has predominantly been undertaken from the perspective of the therapist, through a 'serious treatment failures' lens, and little is known about the perspective of the service user. In particular, no in-depth qualitative research has been conducted to examine the perceived reasons for treatment failure from the perspective of those with OCD who have experienced recurrent CBT treatment failures.

The purpose of the current study was to gain an in-depth understanding of why CBT has not worked from the perspective of service users who have experienced multiple treatment failures. We recruited individuals with OCD who had previously experienced ≥ 2 CBT treatment failures. In order to identify the extent to which any factors identified are specific to OCD as opposed to CBT in general, we also included a comparison group of participants with Panic Disorder (PD) who had similarly experienced multiple CBT failures. PD was chosen as a comparison group as research has shown that the level of impairment of individuals with PD prior to treatment is often similar to those of individuals with OCD (Quilty, Van Ameringen, Mancini, Oakman, & Farvolden, 2003). All participants completed in-depth, qualitative interviews focused on their perceived reasons for previous therapeutic

failures. In addition, we assessed the technical adequacy of previous CBT treatment experiences using a standard checklist, in order to characterise the sample. The specific aim was as follows:

1. To gain an in-depth understanding of the experience of CBT that has failed to help, from the service user's perspective, including the reasons participants perceived their treatment had been unsuccessful.

Method

Design

The adequacy of participants' previous treatment was assessed via completing the self-report Treatment History Questionnaire (THQ). Qualitative interviews (N = 12) were chosen as the most suited method for exploring service users' experience of treatment failure (Edwards & Holland, 2013).

Participants and Recruitment

Participants were eligible for the study if they were $\geq$ 18 years, met diagnostic criteria (as specified by the Diagnostic and Statistical Manual of Mental Disorders 4th ed. (DSM-IV) APA, 1994) for either OCD or PD, identified either OCD or PD as their main problem, and reported having had $\geq$ 2 courses of CBT for this particular problem, which they perceived had been unsuccessful. One OCD participant was subsequently excluded, due to the participant reporting in the interview that their second course of CBT had been successful. A further participant with OCD was recruited. Purposive sampling techniques were used to recruit participants who self-identified as having either OCD or PD and had previously received treatment for this disorder (Robinson, 2014). Six participants were recruited via adverts placed on the website of a UK OCD charity and four via adverts placed on a forum of a UK anxiety charity. In addition, two PD participants were recruited via a research database from a specialist psychological treatment centre.

Measures

Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (SCID-IV) (First, Gibbon, Spitzer, & Williams, 1996).

Participants were administered the OCD or PD relevant section of the SCID, a clinician administered diagnostic interview that is used to determine DSM-IV Axis I and Axis II disorders. The SCID is reported to have acceptable reliability and validity (First et al., 1996).

The Treatment History Questionnaire (THQ) (Stobie, Taylor, Quigley, Ewing & Salkovskis, 2007).

The THQ is a self-report measure that examines participant's reports of past therapies received, providing an assessment of their technical adequacy. The THQ collects information including participant demographics, course of the presenting problem, treatment sought, and information on previous treatment components. With respect to the latter, participants are presented with a list of different techniques, some of which are specific to CBT, whilst others are not, and are asked to tick which elements they recall being a part of their therapy. The THQ includes seven items that are designed to assess if the therapy received meets the minimum essential criteria to be defined as CBT (these items are presented in Table 1, items a. to g.). Participants must report that their therapy met all of the seven criteria for it to be deemed as CBT. The THQ also assesses 12 items which OCD experts regard as essential elements of CBT for OCD (Stobie, 2009). The THQ was originally designed to examine treatment histories of participants with OCD and was therefore adapted for the current study to be applicable for participants with PD by changing the disorder specific information and one of the adequacy criteria[9] (presented in Table 1).

[9] In Panic Disorder a minimum of seven therapy session should be offered (NICE, 2011).

Table 1.

Minimum criteria used to determine therapy as CBT and the 12 items regarded as essential elements of CBT for OCD.

	Minimal CBT criteria	
a.	Six or more sessions	
b.	Sessions lasted for 40 minutes or more	
c.	Exposure (self/ guided) must have taken place at some point during the sessions	
d.	Homework must have been given during the sessions	
e.	The main emphasis of the sessions much have been on the obsessional problem	
f.	The main focus of the sessions must not have been on childhood	
g.	The therapist was not silent for most of the sessions	
	Items specific to CBT for OCD (1-12)	**Modified for PD**
1.	Requesting your patient to go into situations on their own outside of the therapy room to face whatever they are afraid of	N/A
2.	Changing the meaning attached to the thoughts	N/A
3.	Setting homework exercises to do between sessions	N/A
4.	Looking at links between thoughts, feelings and behaviours	N/A
5.	Drawing a diagram explaining the problem, which includes links between thoughts, feelings and behaviours	N/A
6.	Requesting your patient to deliberately expose themselves to frightening thoughts or things in your office	N/A
7.	Concentrating on your patient's beliefs most sessions	N/A
8.	Therapy sessions should last at least 45 minutes each	N/A
9.	Going with your patient outside the therapy room to assist them in facing their fears	N/A
10	Setting the patient reading about the obsessional problem	N/A
11	Asking the patient to keep records of thoughts	N/A
12	Offering at least 10 sessions	At least 7 sessions

N/A = no change was made to these criteria as it was deemed to be applicable to CBT for PD.

Note. Items 1 to 12 are listed in order of experts' mean rating of essentialness from highest to lowest. Items in bold are assessed in the THQ.

Qualitative Interview[10]

A semi-structured interview was developed by two clinical psychologists (JM & PM) who work at a national centre of excellence for the treatment of OCD, and a service user with experience of CBT for OCD. Questions were designed to be a starting point for discussion (Forrester & Sullivan, 2018). Primarily, participants were asked to talk about their experience of their most recent course of CBT that had been unsuccessful, including the factors they perceived had influenced the outcome of their therapy. Following this, participants were asked to focus on the second most recent course of CBT they had undertaken and to discuss if they perceived there to be differences as to why it had been unsuccessful. The semi-structured interview was piloted twice, once each with a person with personal experience of OCD and PD. In response to the pilot interview feedback the questions and their order were modified, and optional prompts were added. During the interview the researcher encouraged participants to elaborate on their answers, provided prompts and sought clarification where necessary. Participants were invited to ask questions throughout the interview and on its conclusion.

Procedure

Ethical approval was granted by the NHS Research Committee (Re: 11/SW/0039). Individuals who contacted the researcher to express an interest in participating were contacted by phone to discuss the study and assess their eligibility to take part. If they met inclusion criteria, they were sent an information sheet, consent form and disorder specific copy of the THQ in the post. Participants provided informed consent and a time for the interview was scheduled. Individual, face-to-face interviews were conducted at the University of Bath and lasted approximately one hour (range 30-120 minutes). Interviews were recorded using a digital voice recorder and were transcribed orthographically, with identifying information being removed and pseudonyms inserted. If participants requested further support, they were signposted to appropriate resources.

Data analytic strategy

The data set comprised of 12 completed THQs and 12 transcribed interviews. Descriptive statistics were used to summarise the data obtained from the THQ, including the clinical characteristics of the sample and the assessment of reports of previous CBT.

The interview transcripts were analysed using thematic analysis (TA), as described by Braun and Clarke (2006, 2013). TA is a flexible method which is well suited to exploring people's

[10] The semi-structured interview schedule is available from the corresponding author on request.

experiences and how they make sense of them. TA was chosen to enable patterns and themes to be derived from the data. The recommended six phase process was followed. The first author familiarised themselves with the data via transcription of the interviews and reading of the interview transcripts. The transcripts were then systematically coded. The data were approached from a critical realist perspective, which assumes that the data represent a valid report of the participant's reality, explained by the way in which the participant talks about their experiences and the meaning this has for them. The analysis was conducted by the first author, a clinical psychologist experienced in the treatment of both OCD and PD. An inductive approach was utilised, meaning that the data were the starting point for analysis rather than applying pre-existing theories to the data. However, it should be noted that the author's CBT orientation, clinical and academic knowledge is likely to have influenced the analysis and therefore to some extent a deductive approach is incorporated. Semantic and latent codes were identified. Codes were then arranged utilising a thematic map to identify initial candidate themes. A second clinical psychologist with comparable experience reviewed three transcripts from each disorder specific group. The second reviewer initially read through the transcripts and made notes on potential codes and then themes. Following this, they were provided with the theme structure that had been developed and were asked to comment on the themes and associated interpretations. The second reviewer suggested three changes to themes which were further discussed, with two changes being made. A thematic map displaying the themes was developed for each disorder. The two thematic maps were compared to examine where the similarities and differences between the two disorder specific groups existed. The results from both groups were then merged to create one thematic map representing the findings from both groups. The first author then met with the co-authors to present the thematic map and to discuss and review both the thematic map and corresponding data. This review led to the merging of several smaller subthemes and the titles of overarching themes being refined.

Results

Participants

To contextualise the sample a demographic summary of participants' characteristics and treatment history is presented in Table 2.

Table 2.

Participant characteristics and treatment history

Demographics		**OCD**	**PD**
		***N* (%)**	***N* (%)**
Gender	Male	2 (33.3)	4 (66.6)
	Female	4 (66.6)	2 (33.3)
Ethnicity	White	6 (100)	6 (100)
Education	High school completed	2 (33.3)	1 (16.6)
	Diploma	2 (33.3)	3(33.3)
	Undergraduate degree	1 (16.6)	2 (33.3)
	Postgraduate degree	1 (16.6)	-
Employment	Unable to work due to OCD/PD	2 (33.3)	2(33.3)
	Employed part time	2 (33.3)	1(16.6)
	Employed full time	1 (16.6)	3 (50)
	Unemployed	1 (16.6)	-
	Other (carer, retired)	1 (16.6)	-
		M (SD)	***M (SD)***
Current Age		46.5 (10.17)	38.8 (7.25)
History of OCD treatment		***Median (R)***	***Median (R)***
Number of past sets of therapy		3 (2-5)	2 (2-3)
Number of past sets of CBT		2 (2-4)	2 (2)
Longest duration of being free from OCD/PD symptoms (months)		6 (0-36)	10 (0-36)

N = Number of participants; *M* = Mean; *SD* = Standard deviation, *R* = Range

Reported adequacy of CBT and adequacy of CBT specific to OCD

It was found that 100% of both OCD and PD participants' *most recent course* of therapy met all of the seven minimum criteria specified for an intervention for therapy to be defined as CBT (Table 1). Thus, the entire sample had received a minimally adequate version of CBT. However, for the penultimate course of therapy 33% (*n* = 2) of OCD and 50% (*n* = 3) of PD participants reported therapy did not meet the defined minimal criteria for adequate CBT (one OCD and two PD participants had not been allocated homework and one OCD and PD participant reported that the main emphasis of the sessions was not focused on the problem).

When examining the 12 components of the THQ judged to be 'essential' elements of CBT for OCD, half of participants with OCD (*n* = 3) endorsed their most recent version of therapy to have included all 12 of the essential elements measured. All OCD participants reported that their most recent therapy had included at least six of the essential elements. This suggests that participants' treatment failure may have been due to 'serious treatment failures' rather than being due to 'technical treatment failures'. A similar level of adequacy was reported by PD participants when examining the wider set of disorder specific treatment criteria. However, fewer PD participants (*n* = 2) reported 'therapist assisted exposure' in their most recent course of CBT. For both groups, their most recent experience of CBT was recalled as being more technically adequate in comparison to their previous course of CBT.

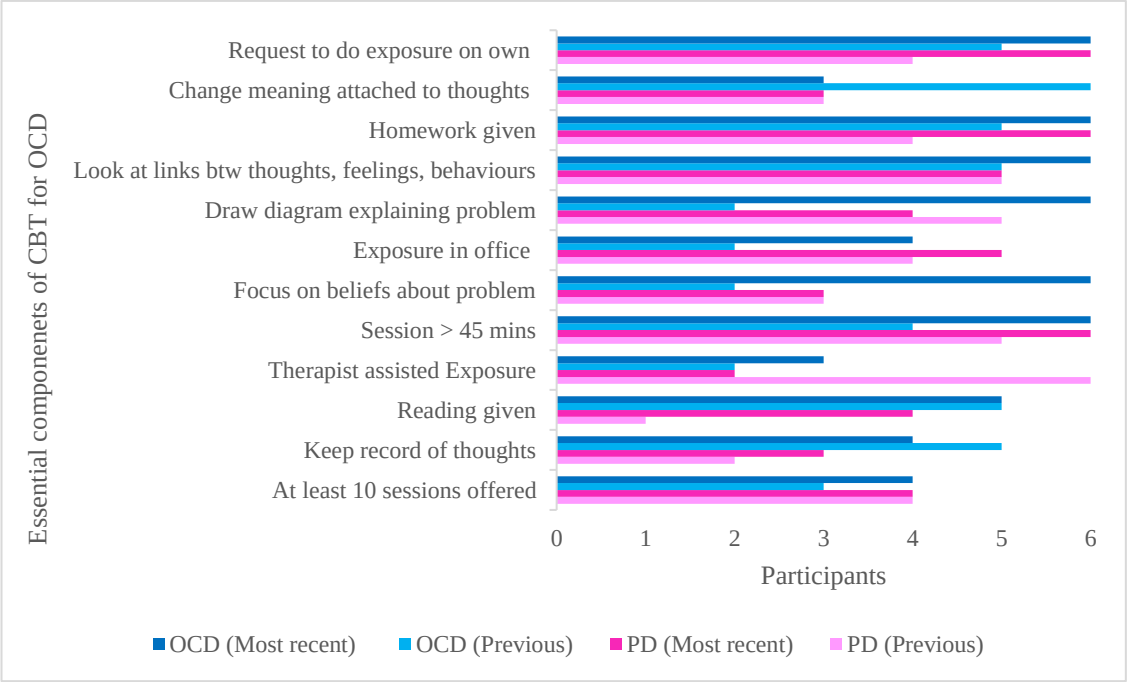


Figure 1. Participants' recollections of essential elements of CBT in past courses of therapy.

Qualitative Analysis

Analysis of the experience of treatment failure and perceived reasons for this identified three overarching themes: 1) *Invalidating and Disempowering Experiences*; 2) *Factors Relevant to Formulation and Socialisation*; and 3) *Wider Barriers to* Recovery. The first two themes were shared by both OCD and PD participants and the third was specific to OCD. Each overarching theme comprised three subthemes. See Appendix 1 for a visual representation of the overarching and subthemes.

Overarching Theme 1: Invalidating and Disempowering Experiences

This theme represented the interpersonal experiences and exchanges between the service user and therapist. Participants described what they 'brought' with them to therapy (i.e. presenting problem and their experiences of this) and how they felt this was received by the therapist. Participants reported on how they perceived the stance and intentions of their therapist. These factors were relevant to the building of rapport and the foundations of an effective therapeutic alliance or alternatively the undermining of it. Three subthemes were identified; 1.1) *The feeling of not being understood*; 1.2) *Failure in OR loss of collaboration and effective therapeutic rapport* and 1.3) *Factors that lowered expectations of likely success*

Subtheme 1.1: The feeling of not being understood (OCD & PD).

This subtheme, which was present in both OCD and PD, represented the different ways in which participants did not feel understood by their therapist, and the reasons why that was important. Participants discussed the magnitude of the struggle that precedes help seeking; a deep sense of shame that was often reported to be associated with admitting there was a problem and voicing the details of the problem, and consequent feelings of vulnerability that accompanied telling the therapist about their problems. Participants described the experience of feeling as though they had not been 'got' as being a failure on the part of the therapist to grasp either the specifics or the severity of their problem, which simultaneously contributed to the maintenance of underlying concerns.

> *It was a big thing for me to admit that, that was, what I was, and I was utterly ashamed as well, I felt so ashamed of myself, embarrassed, but he didn't do anything to make me feel better or that I had a problem that could be understood. I don't think he understood my problem. And I don't think he understood me, how sort of intrusive and engrained the OCD had become in me, I don't think he sort of took that very seriously really (OCD Participant 1).*

> *She clearly, by the end of it [therapy] hadn't grasped that it [panic] was as bad as it was. I guess, being brutal about it she just didn't understand my problem (PD Participant 6).*

Subtheme 1.2: Failure in OR loss of collaboration and effective therapeutic rapport (OCD & PD).

This subtheme encapsulated the ways in which collaboration can fail and highlighted how a non-collaborative approach can be central to disengagement. The value of the collaborative process, whereby the service user and therapist work alongside one

another and have shared input, was emphasised by participants. This was reported as being fundamental, particularly when deciding on the focus of therapy (i.e. which aspects of the problem participants perceived most important or were interfering most in their life).

> *He [therapist] wouldn't do the exposure prevention again because he'd say, "I've already given you the tools, you know how to do it, you've got to do it, I'm not going to do it again, we're going to do more cognitive work and find other methods of tackling this washing problem that's come back again". I probably wanted more help with the contamination. I had hoped for more exposure and prevention, but he didn't want to do that because he said, "I've already taught you that" (OCD Participant 6).*

Some participants reported regularly attending therapy with a list of new concerns they wanted to discuss. These participants reflected that this had been potentially unhelpful as it had diverted the focus of therapy and may have impeded therapy progress. However, it was reported that this pattern was not addressed effectively by the therapist, and this was linked back to the difficulties associated with the absence of effective therapeutic rapport.

> *I'd tend to come along with a short kind of list of immediate concerns. I think, maybe the therapist wasn't in a way tough enough with me, in a sense of saying "well, you're now talking about this, this week, but how does that relate to what we did last week". I wonder if the therapy did slightly lose its way (OCD Participant 2).*

Within the OCD data, several participants described failures in collaboration. These appeared to result from differences in opinion, which were not resolved in a collaborative manner. This included a view of CBT being prescriptive, rather than idiosyncratic. It was evident that OCD participants, having experienced several previous courses of CBT, had well developed ideas and expectations about how therapy should be for them and the elements it should include. Participants described bringing this knowledge with them to the therapy sessions and the difficulties that arose when their views were not shared.

> *I think the "traditional CBT" as she called it, the exposure and ritual prevention, needs modifying for OCD. I don't think you can just do the one size fits all […] I feel she should have tried a different approach, and she should have listened to how I was feeling and what I was saying, rather than just expecting me to follow the*

program […] One thing that I did mention to her that was useful, was distraction, and she said that was completely against what the therapy was trying to do, she said that distraction was just a way of not facing up to the problem that was making things worse […] I'd been reading a [OCD self-help] book and part of that included distraction, and I was finding that quite useful and helpful. But she was quite certain that it wasn't […] I was using it [distraction] to resist washing and doing something that I enjoyed instead (OCD Participant 3).

This subtheme also reflected the failure between the therapist and patient to establish an effective therapeutic alliance and spoke to how this was a focus for some service users in discontinuing CBT.

I guess you have to, have a bit of a therapeutic sort of connection, and I guess we just didn't have that at all. I probably just really irritated him or something, I don't know […] I didn't feel like he was wanting to help me [...] He wasn't a horrid man, but I just don't think he related to me, and I think you sometimes need to be able to relate to that person. I actually wrote to him and said that I didn't want to continue, because I just felt like, we weren't really getting anywhere (OCD Participant 1).

Subtheme 1.3: Factors that lowered expectations of likely success (OCD & PD).

Participants in both groups reported that the way in which their therapist spoke about the therapy they were providing was often not specific to the disorder or, in their opinion, revealed that the therapist was inexperienced in providing such treatment. This instilled doubt in participants' minds with regards to the therapist's knowledge and ability to provide a treatment that would be relevant and potentially helpful.

With the whole rumination about harming the baby thing, he said himself, until he'd been to this conference, he'd never sort of heard about it, which made me feel even worse. I mean he was a psychologist and he was quite an older man, so I think he'd probably been in practice quite a long time, but I just felt the whole point of me going was being missed. I think sometimes practitioners have been in the job for so long and perhaps they don't always do more learning, they just do what they already know. If that was me, I'd go off and I'd read a bit about it, he clearly hadn't done any of that, which made me lose all confidence in him (OCD Participant 1).

I don't think my therapist had an expectation that I could be cured […] And at the end she said, that, "CBT is excellent for curing phobias, but it's not such a, not so likely to cure panic or anxiety" (PD Participant 4).

Independent of therapists' level of skill, participants talked about their confidence in their therapist based on the therapist's delivery of the therapy. This relationship was bidirectional, with therapists reportedly conveying a lack of confidence in their patient's ability to make substantial progress or the likely effectiveness of the treatment itself.

My symptoms started about aged 21, and I'm now 66. I'm quite an experienced sufferer from OCD. And so, I think we both agreed, which I think was sensible, that it's unlikely that I'd make absolutely dramatic progress […] I think he literally kind of said, you know, in the first or second session, "I don't think we're going to be able to do very much with you", but he remained positive (OCD Participant 2).

Overarching Theme 2: Factors Relevant to Formulation and Socialisation

In this theme participants described aspects of the content of the CBT they had received and the difficulties they experienced with engagement, due to how they made sense of the content and how it was delivered. Three subthemes were identified which included; 2.1) *The leap between theory and practice*, 2.2) *Poorly communicated rationale* and 2.3) *Too terrifying to take part: Partial engagement.*

Subtheme 2.1: The leap between theory and practice (OCD & PD).

Participants described a gap between talking about what one might need to do to begin to overcome their problem and the act of undertaking this in practice within real life contexts. Participants described the lengths that they perceived ERP or Behavioural Experiments (BE) needed to go to, in order to be effective (i.e., staying in the feared situation until anxiety had habituated). Participants described thinking that the ERP or BE had not gone far enough to be effective, although they reported that they had often not communicated this to the therapist.

We did get out of the office to do things, it was challenging but not challenging enough. It didn't, it wasn't taken far enough. At the time I was having a lot of trouble with shops, and crowded places, so we went into shops but very briefly really. It seemed quite, not paying lip service, we didn't stay there very long. I still felt anxious when I left the shop, I don't think it was sufficient exposure (PD Participant 4).

Some participants reported that while they were able to engage with therapy from a theoretical perspective, they did not find it helpful from a practical point of view.

> *Examining the thought processes, and the responses that you're making. I mean, I have found it quite interesting in terms of understanding the fight or flight reflex, and the, you know, what's going on with the brain, and why these things happen. But I didn't find it at all effective in actually treating my disorder (PD Participant 5).*

Emphasis was placed on the perceived importance of undertaking ERP or BE in-session supported by the therapist, in order to be able to do this beyond the session autonomously.

> *It was all based in her office, we didn't go out at all or have any exposure treatment. If the therapist could have come with me to start with and shown me what I needed to do, it's a big step from them saying what it is you need to do and then being able to go home and do it on your own. I think that is the main thing that could have helped because you're actually physically doing it and facing your fear (OCD Participant 5).*

Subtheme 2.2: Poorly communicated rationale (OCD & PD).

This subtheme depicts participants' experiences of their understanding of the meaning and purpose of aspects of the therapy process, including the ERP/ BE they were asked to undertake in therapy. Participants in both groups described experiences in which they did not have a clear understanding of the rationale, it was missing, or was no longer memorable in their mind. This resulted in the associated task appearing to lack validity and feelings of frustration with the therapy process.

> *He [therapist] tried to encourage me to keep up with it and to keep it going, because, I'm not sure of the reasons why, but it was like, "how do you feel leaving the house today", and then I think there was strategies of coping, but I can't remember what they were I'm afraid (OCD Participant 4).*

> *One of the things he would encourage me to do would be to take the bus further afield to somewhere like (location) which is like maybe 15, 20 miles away, and just come back, you know, just for the sake of doing it. But I'd think, what's the point in doing it without a reason for going there, you know? (PD Participant 3).*

Participants with PD also raised questions about the overall value and suitability of CBT as a treatment for PD. A rationale for how CBT could work for their difficulties had not resonated. Several participants reported that their problem was too chronic, severe or entrenched for CBT to be a suitable treatment.

> *The therapy I did, it wasn't, it wasn't useful for somebody that had suffered it for years. There's not much therapy, well I've not come across therapy, to deal with that end of it really. I think it would be absolutely perfect for somebody who for the first time in their life is experiencing panic attacks (PD Participant 2).*

Subtheme 2.3: Too terrifying to take part: Partial engagement (OCD & PD).

Within this subtheme participants in both groups articulated the belief that what they were being asked to do was not possible due to the high level of anxiety it would evoke. Some agreement was expressed regarding the tasks being a good idea, but a mismatch between this and the reality of undertaking them was evident.

> *Just that it's very hard to do, when you're absolutely terrified. And when I was really ill, I'd be terrified constantly [...] So when I got to therapy and he'd say we're going to do this and this, I'd be like "oh, get lost, you know, I'm dying here" (PD Participant 3).*

Unique to OCD, participants described being unable to fully engage with therapy due to the idea of different obsessions varying in their levels of value and associated responsibility and risk. This variation resulted in a willingness to tackle some obsessions and prohibited them from tackling others. Linked to this, participants reported the experience of engaging in 'half exposure,' continuing to utilise safety seeking behaviours.

> *It was necessary to me in my mind to check everything, so I wasn't able to do it. I was able to cut it down, but not stop. I think it was the 'what if' scenario. If I didn't check and there was a fire, for instance, I would lose everything […] Somebody saying your work's not good enough wouldn't affect me as much, as if my house burnt down, for example (OCD Participant 4).*

Overarching Theme 3: Wider Barriers to Recovery (OCD only).

This overarching theme and its three subthemes were all specific to OCD. It concerned factors that were central to the individual that made overcoming OCD more difficult and were perceived by participants as prohibitive to their engagement, progress and generalisation of skills learned. Three subthemes were identified; 3.1) *Lack of family and social support*, 3.2) *Dealing with problems beyond diagnosis* and 3.3) *Not enough therapy*.

Subtheme 3.1: Lack of family and social support (OCD only).

Participants perceived a lack of family and social support and consequent social isolation as being problematic. Several participants attributed a lack of familial support as contributing to their difficulty in overcoming OCD and perceived that better progress may have been made if external support had been available to them. The idea of not having anyone to be accountable to or to help them, leading to their OCD becoming more pervasive, was expressed.

> *You can be taught the tools, but if you have nobody to be accountable to or to support you, you can't use those tools. I think that's my problem. Because I live [on my own], you know, my OCD means I'm very isolated socially. I don't ever, I don't let people into my flat hardly at all. I don't have anybody to help me to do it, you know. I don't think you can. I don't think you can overcome, people who overcome OCD seem to have, you know, other people around them. When you're on your own it's really, really hard (OCD Participant 6).*

Subtheme 3.2: Dealing with problems beyond diagnosis (OCD only).

OCD participants highlighted major unmet social care needs that had a significant impact on their daily functioning, and their consequent wellbeing and ability to engage in CBT when it was being offered to them. Of course, such difficulties arise, at least in part, due to the extent of the disability caused by the OCD itself, highlighting the circularity of the problem (i.e. the extent to which OCD is disabling can lead to numerous obstacles to engaging in treatment).

> *The problem is with CBT I've noticed, it's not part of an integrated service, it happens in a bubble, in a vacuum, which CBT therapists have absolutely no interest in the rest of the mental health services or where their therapy fits in, in your life. I've spoken to a lot of people about this because other people have said, "well, you know the therapy came at the wrong time in my life and it was really rubbish". For*

me it was 10 days before I was going to be made homeless, I had no money, wasn't working, I was getting into debt. So, to have therapy when those needs haven't been met, well, if you literally don't even know where your next meal is coming from, you know, your life is, you know, the priority is food, clothing, roof over head, before you start having therapy (OCD Participant 6).

Subtheme 3.3: Not enough therapy (OCD only).

This subtheme conveys OCD participants' views that not having enough sessions of CBT was a contributing factor to overall outcome. Participants reported that therapy ended before adequate progress had been made and a sufficient amount of therapy had been received. For some this was due to the restriction on the number of sessions that could be provided by the service. In other cases, this was a result of the therapist leaving the service and the therapy ceasing as a result. One participant felt that the hourly 'format' in which therapy was provided was too short to achieve meaningful gains.

The sessions were cut off, I guess it was laid down, this many weeks were laid down by the local NHS and that's it, "off you go". I wasn't given any option about continuing […] there weren't any booster sessions or anything like that. I think I would have benefited from more sessions, to be honest with you (OCD Participant 5).

Discussion

The main purpose of this study was to provide an in-depth examination of the factors perceived to contribute to therapy failure from the perspective of OCD service users, with a focus on those with experience of multiple CBT failures. We included a comparison group with PD, to provide information about whether any issues identified were specific to OCD, versus reflective of wider contributors to therapeutic failures. The technical adequacy of participants' previous CBT was assessed by the THQ, and results suggested that participants in the study had undertaken at least one previous course of technically adequate CBT. Themes identified from qualitative analysis reflected participants' views on an individual level and therapeutic factors that contributed to treatment failure.

The THQ indicated that participants' most recent course of CBT had been technically adequate for the majority of OCD and PD participants. This contextualised the current sample, suggesting that non-response is likely to have been, for at least some participants, due to 'serious treatment failures' (Rachman, 1983). Despite the likely technical adequacy of the CBT provided according to standard checklists, findings from the qualitative analysis

indicate that participants were dissatisfied with the therapy they had received and perceived aspects of its delivery to be inadequate. The reasons that participants perceived their treatment had failed them fell under three overarching themes, which encompassed perceptions of the therapist's engagement (Theme 1: *Invalidating and Disempowering Experiences*), the individual's ability to understand and engage with the therapy being offered (Theme 2: *Factors relevant to Formulation and Socialisation*), and personal and service related circumstances which related to participants' perception of their capacity to engage in treatment (Theme 3: *Wider Barriers to Recovery*). Themes 1 and 2 were shared by participants with both OCD and PD, suggesting that the factors identified relate to therapeutic interactions and to CBT more broadly rather than to OCD specifically.

In theme 1 (*Invalidating and Disempowering Experiences*) a major factor that contributed to treatment failure, in the eyes of study participants, was a fundamental failure on the part of the therapist to understand the individual and their problem, and to give them confidence in the therapy being provided. Participants described invalidating and disempowering experiences, which were perceived to be a consequence of poor therapist insight, a breakdown in therapeutic collaboration and rapport, and communication by the therapist which led participants to lose confidence in them. The subthemes of theme 1 were interrelated, meaning that if difficulties arose in one of these areas it created a knock on or domino effect. For example, if in the early stages of therapy, the patient perceived the therapeutic interactions to mean that they had not been understood this led the patient to lose confidence in their therapist's ability to help them, or to a loss in collaboration. This may then have led the service user to lose faith in the therapist's competence and in turn their own confidence and ability to take part in the therapy, affecting their engagement in the therapeutic relationship. The absence of an effective therapeutic alliance is likely to impact on the patient's trust and affect their willingness to explore and take required therapeutic risks, potentially resulting in the difficulties encountered with the leap between the theory and practice of ERP or BE which is inevitably required (as described within theme 2).

Within the CBT literature therapeutic alliance has often been viewed as a 'necessary' but not 'sufficient' aspect in itself to cause change (Beck, Rush, Shaw, & Emery, 1979). A meta-analysis examining the relationship between therapeutic alliance and outcome, concluded that there is a small relationship (r =.22, approximately 5-6% of the variance) between alliance and outcome and the strength of the alliance is associated with outcome (Martin, Garske, & Davis, 2000). This meta-analysis also reported that patients generally view alliance consistently throughout the course of therapy, meaning that their initial view of the alliance is unlikely to change. This fits with the findings of the current study,

highlighting the importance of the therapist establishing a positive effective alliance at an early stage of therapy (Martin, Garske & Davis, 2000). However, as emphasised by the results of the present study, an 'effective positive alliance', is not synonymous with a consistently 'good' relationship. An effective working alliance is the basis from which patients can feel safe and supported to take risks and make behavioural and cognitive changes. It is thus important that therapists are cognisant of this distinction.

Perceived problems in the therapeutic alliance were also evident in theme 2 theme (*Factors relevant to Formulation and Socialisation*). Within this theme, participants described a *poorly communicated rationale* (subtheme 2.2) being an obstacle to engagement, making the *leap of faith* (subtheme 2.1) that is fundamental to full therapeutic engagement much more difficult to take. Being *too terrified to take part* (subtheme 2.3) was also part of this theme for both OCD and PD participants, with some participants being too anxious to engage with tasks at all. OCD participants also reported only partial engagement, where they relinquished only some safety-seeking behaviours. Underlying these variations in difficulties with engagement is a *poorly communicated rationale* with regards to what is being done in therapy and why and how what is being proposed fits with the formulation. Perceived failure on the part of the therapist to be sufficiently convincing and supportive highlights some of the challenges to delivering interventions to highly anxious individuals. In their paper on 'therapist drift', Waller and Turner (2016) discuss therapists' potential ambivalence towards the evidence-based use of CBT change techniques due to therapist concern regarding the perceived distress it may cause the patient. Waller and Turner (2016) refer to the idea of therapists employing their own 'safety-behaviours'. Such safety-behaviours prevent therapists from encouraging patients to change due to fear that they will be viewed less positively or the wish to protect themselves from the patient's emotional distress (Deacon & Farrell, 2013). Farrell, Deacon, Kemp, Dixon, and Sy (2013) also discuss the use of therapists' suboptimal delivery of ERP due to therapists' negatively held beliefs resulting in cautious delivery (e.g. prematurely terminating exposure tasks, not venturing outside of the therapy room).

It is clear that the method in which CBT for OCD is delivered is important, with therapist supported in-vivo ERP, in conjunction with imagery, producing the greatest change in symptom severity (McKay et al., 2015). This raises the question as to whether it is possible that therapists themselves, may at times be responsible for 'treatment interfering behaviours'. In Pollard's (2006) 'Identifying Treatment-Interfering Behaviours' (TIB) questionnaire, several of the items mirror the reports of participants regarding their therapist. For example, item two states: "Does not adequately or consistently acknowledge the

problem's severity or its impact on others", item three: "Does not identify clear goals for treatment", item six: "Has difficulty explaining the treatment plan or the rationale behind it". This emphasises the importance of true collaborative working in CBT, and the importance of the therapist taking responsibility for checking in with the patient to ensure that there is a shared understanding with regards to what has been covered and discussion of both parties' views on this.

The implications of patients' treatment literacy should also be considered more widely. Participants in this study often had a clear idea about what they should be receiving in therapy. When the patient and therapist disagreed, it should be acknowledged that we do not have sufficient information to discern whether what the individual perceived to be necessary was in their own best interests. As a therapeutic rule, the onus remains with the therapist to discuss with their patient the efficacy of the therapy they are providing, and to develop a shared understanding of how the patient's problem works and how the treatment being offered fits with this. However, clearly this can be particularly challenging where individuals have experienced multiple treatment failures.

The final theme (*Wider Barriers to Recovery*) highlighted complicating factors that were specific to OCD and were deemed to fall outside the parameters of either technical or serious treatment failures. These included a *lack of family support* (subtheme 3.1), the fact that individual were *dealing with problems beyond their diagnosis* (subtheme 3.2), and the perception of individuals that the amount of therapy available as standard was simply *not enough* (subtheme 3.3) to address their problem. The negative impact of family accommodation of OCD on the sufferer (Steketee, Van Noppen, Lam & Shapiro, 1998) and the distress experienced by family members (Amir, Freshman, & Foa, 2000) and their effect on treatment outcome is well documented, although was not reported in this sample. Instead, participants described a relationship between a lack of being accountable to others and the pervasiveness of their OCD. In addition, the reported lack of family and social systemic support was described to result in social isolation and difficulties in being able to fully take part in CBT. While a high level of comorbidity, particularly with depression (Overbeek, Schruers, Vermetten, & Griez, 2002) could have been expected to be a significant issue in a sample of participants who have previously not responded to CBT, this was also not raised. However, this was not specifically addressed or measured in this study which could potentially account for its absence.

Ten hours of CBT is identified as the minimum number of hours required for technically adequate CBT (NICE, 2005). However, in practice, and as reported by

participants this is often not a sufficient number of hours to treat severe OCD. Moreover, the specific number of therapy hours that a patient is allocated is rarely the decision of the treating therapist but is rather a product of the treating service's policy. Within the efficacy literature an 'optimal trial' of CBT is considered to require much longer than 3 months (McKay et al., 2015). There is a clear dose-response effect, with the greater number of hours of CBT provided the better the outcome for patients (Hansen, Lambert, & Forman, 2002). There is also evidence that more time is required when the therapist delivering the intervention is not a specialist (Fisher & Wells, 2005). The personal (and economic) costs associated with the experience of yet another unsuccessful course of CBT are serious (Boisseau, Schwartzman & Rasmussen, 2017). Ultimately, this could make the difference between whether the service user resolves their OCD or continues to be significantly affected by it.

Clinical Implications

The majority of participants with OCD were particularly treatment literate. They were informed on the elements they believed CBT for OCD should consist of and how it should be delivered. As these participants had experienced two or more courses of CBT there was room for comparison between treatments. The results of the present study suggest that, from a therapist's perspective, it may be useful to consider creating room early on in therapy to discuss this, to acknowledge and integrate the service user's prior experience, insights and knowledge. This may also be crucial for preventing the possibility of patients comparing previous treatments with the current therapy and thus potentially undermining the current therapy they are attempting to undertake. Also, of relevance is remembering to return to basics such as collaborative agenda setting to ensure the focus of the session remains on OCD and in-session drift is prevented (e.g. collaboratively agreeing how new issues not relevant to OCD will be addressed or made time for in the session e.g. revisiting in the final 10 minutes of the session if still required at that point). The results of the study also suggest that considering the level of the patient's familial support and having a grasp of external issues that may be in play, may be therapeutically useful.

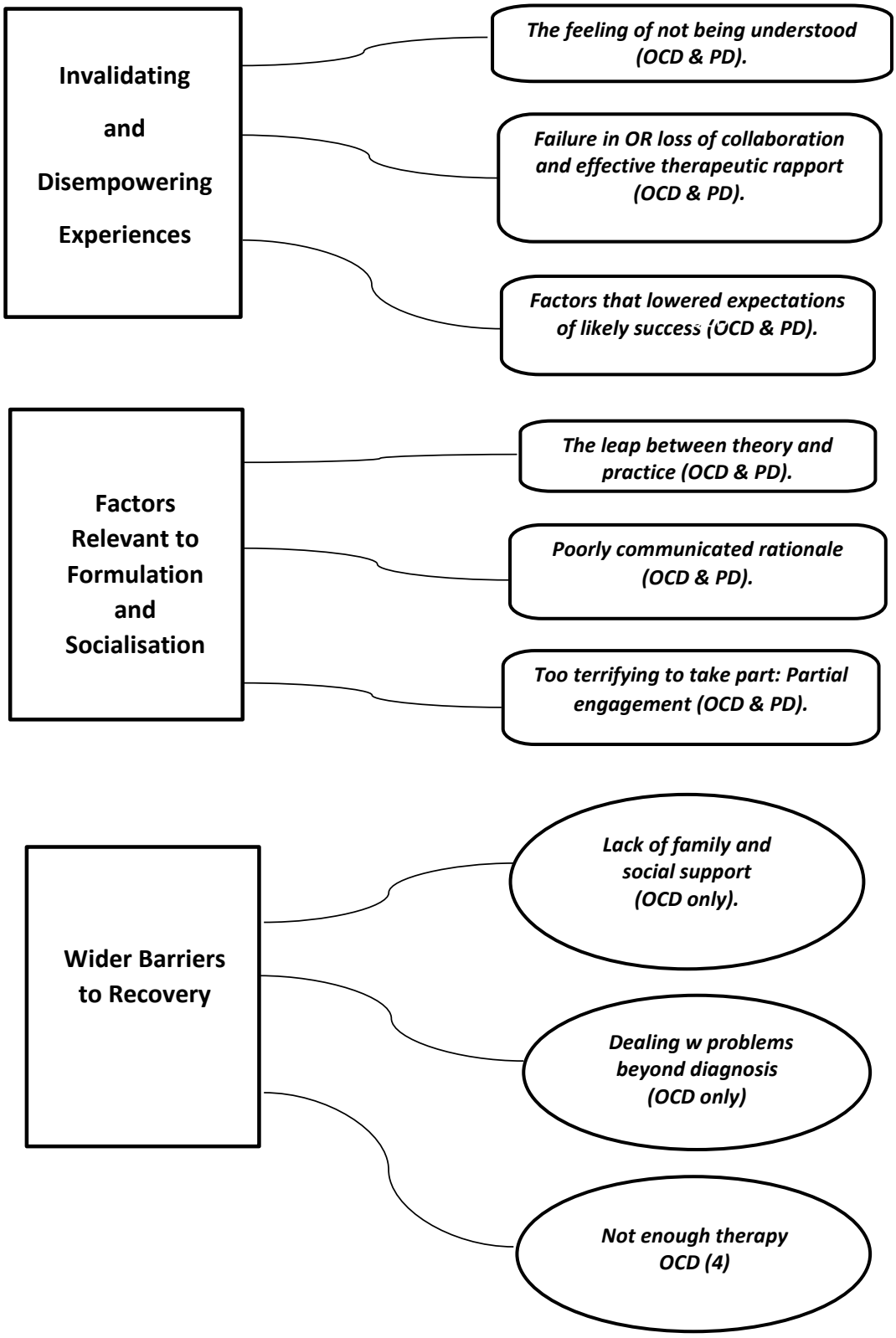
Limitations and Future Research Directions

A relatively small number of participants took part in this study; although purposive, it was nonetheless a sample of convenience. It should be noted, that these findings are not intended to be generalizable but are transferable to this specific group of service users, providing important in-depth insights that would not be captured from quantitative studies alone.

In the present study, the THQ was used to gain information about participants' recollection of what was done in their previous CBT and to gain an insight as to whether participants had previously received technically adequate CBT. A limitation is the potential for recall bias in participants' report. Future research which cross validates participants' reports with case files would be useful in circumventing this potential recall bias. It would also be useful to include a broader and larger group of participants for a study of this nature.

The perspectives captured were confined to those of the service users, thus the perspectives of the therapist are required to provide a full understanding of the factors involved. Future research designed to individually examine both the service user and therapist's experiences before, during and after the course of therapy would be useful in gaining a more in-depth picture. Ideally, this study would be designed to capture therapist and patient dyads, with the dyads completing independent session-by-session outcome measures. This would allow for an examination of how closely matched the therapists and participants perspectives are in terms of what is happening in therapy. This design may help to further illuminate the factors that lead to non-optimal responses to therapy.

Appendix 1: Thematic Map representing the identified overarching and subthemes.



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CHAPTER 7: STUDY 3

Intensive Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: Perspectives of Service Users

Chapter Rationale

Study 2 established that participants mainly attributed the failure of their previous CBT to aspects of the therapeutic interaction as well as aspects of its delivery being inadequate. Participants also identified specific factors such as the absence of therapist assisted ERP as potentially responsible for treatment failure. One possible practical solution to ensure there is adequate time in-session for important elements of CBT to take place (i.e., in-session ERP) is to examine different modes of treatment delivery.

Study 3 therefore uses qualitative methodology to examine participants' views on the prospect of an intensive version of CBT. From a therapist's perspective it is hypothesised that a potential benefit of an intensive format is the opportunity to engage the patient in the cycle of experiential learning repeatedly during and across sessions. Kolb (1984) states that learning is the "process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience" (Kolb, 1984, p. 41). Thus, it is expected that this will help the individual to grasp these experiences and transform the experiences they have into knowledge According to NICE (2005) guidelines, intensive interventions are recommended for individuals with OCD who have experienced multiple treatment failures. However, the perspective of potential users of such a service is unknown. The focus of Study 3 is therefore on gaining in-depth insight into perceptions of intensive format CBT amongst individuals with OCD who have experienced multiple treatment failures.

This declaration concerns the article entitled:			
Intensive Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: Perspectives of Service Users.			
Publication status (tick one)			
Draft manuscript [x] **Submitted** [ ] **In review** [ ] **Accepted** [ ] **Published** [ ]			
Publication details (reference)	Millar, J.F.A, Salkovskis, P.M., Gregory, J. & Halligan, S. L.		
Copyright status (tick the appropriate statement)			
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Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.		
Signed		**Date**	27.09.2019

Intensive Cognitive Behavioural Therapy for Obsessive Compulsive Disorder: Perspectives of Service Users

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Abstract

Background: The National Institute of Health and Care Excellence (NICE) recommend an intensive version of treatment for service users who have not responded to ≥ 2 treatments for Obsessive Compulsive Disorder (OCD). The views of service users for whom this format of treatment is recommended are unknown.

Method: Thirty semi-structured telephone interviews were conducted with participants with OCD. All participants had previously undertaken ≥ 2 unsuccessful courses of CBT. Interviews were analysed using thematic analysis.

Results: Participants reported that an intensive format may provide the time required to tackle important aspects of therapy that were not achieved or tackled during weekly CBT (e.g. in-session ERP). Individual preference is seen to play an important role and consequently an intensive format will not be well-suited to all who have experienced previous CBT failure. Four themes were identified: 1) Continuity and momentum, 2) Hmm, yes, but…: reservations about intensive CBT, 3) The fortune is in the follow-up, and 4) Understanding individual preference.

Conclusion: Findings support the NICE recommendation, with participants with OCD who have experienced multiple CBT failures perceiving intensive CBT to be a broadly acceptable with potential therapeutic advantages. Reservations related to the possibility of relapse were expressed. Clinical implications and future research directions are discussed.

Key words: Obsessive Compulsive Disorder, OCD, Intensive Cognitive Behavioural Therapy, iCBT, CBT, Treatment failure, NICE guidelines

Introduction

Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) is recognised as the first-line and most effective psychological treatment for Obsessive Compulsive Disorder (OCD) (NICE, 2005, 2018; Öst et al., 2015). However, approximately only half of those who receive CBT experience full remission from this treatment (Farris et al., 2013; Rasmussen & Eisen, 1997). Partial treatment response results in high rates of relapse (Eisen et al., 2013; Pallanti et al., 2002) continued service user distress and disability (Hollander et al., 1997), re-referral, and utilisation of services. The costs associated with this are high both for the individual affected and economically (Dobson & Beshai, 2013).

Research has traditionally examined treatment non-response from the perspective of the therapist, where patient factors such as poor engagement with ERP/ Behavioural Experiments (BE), noncompliance with homework and comorbidity are frequently identified (Sanderson & Bruce, 2007). However, more recently attempts have been made to investigate treatment non-response from the perspective of service users (Millar, Halligan, Gregory and Salkovskis, in prep.). Millar and colleagues (in prep) employed qualitative methods with the aim of understanding the experience of non-response to traditional CBT for OCD through the eyes of the patient (Millar et al., in prep). This study's findings are consistent with those cited by therapists above, but differences were apparent in terms of the context in which these factors are perceived to occur and who they are attributed to. Service users perceived their non-response to CBT to be associated with difficulties in being able to fully engage with ERP. Reasons for this were described as interrelated and included: ineffective therapeutic alliance, insufficient treatment rationale, absence of therapist assisted/modelled ERP and insufficient time within the session. Thus, from the patient's perspective, treatment failure was largely attributed to the therapist.

One potential solution to the therapeutic interaction difficulties described by participants (Millar et al., in prep) may be to examine the format in which therapy is delivered. CBT for OCD is most commonly delivered on an outpatient basis in which the service user attends one office-based session per week, for approximately 45-60 minutes, over a period of 10-20 weeks (Beck & Beck, 1995). However, for service users with OCD who have not responded to $\geq$ 2 adequate treatments, NICE (2005, 2018) stepped care guidance recommends an intensive version of treatment. This recommendation is in line with research suggesting that an intensive treatment should be considered for those with 'treatment refractory' OCD (Storch, Gelfand, Geffken, & Goodman, 2003). The design of an intensive treatment (i.e. several hours of therapy delivered each session, with more than

one session per week) may facilitate the time required for factors related to therapeutic interaction to be picked up on in therapy and subsequently addressed. Several other reasons have been identified as to why an intensive format should be considered for OCD. For instance, clinical improvement in a short time may be crucial for individuals whose job or relationship is at risk (Oldfield, Salkovskis, & Taylor, 2011) and may also provide a solution when geographical distance from treatment centres is an issue (Oldfield, Salkovskis & Taylor, 2011). Therapeutic advantages such as providing a focused period of time in which the individual can concentrate on their recovery with minimal distractions from job responsibilities or childcare are noted (Shikatani et al., 2016). The intensive format may also help with continuity of treatment, enabling both the patient and therapist to keep therapeutic work fresh in mind. It may be particularly useful for overcoming avoidance and difficulties associated with depression, with less time required to build momentum (Ehlers et al., 2010) and thus more time to focus on exposure based tasks.

To date, only one study has qualitatively examined service users' views on an intensive outpatient version of CBT (Bevan, Oldfield & Salkovskis, 2010). This study focused on the perceived acceptability of intensive CBT in comparison to weekly CBT in patients with OCD. This study provides some evidence for the acceptability of intensive CBT. Participants who undertook intensive CBT chose to do so and at the completion of therapy all participants expressed a definite preference for intensive CBT. Nonetheless, Bevan and colleagues (2010) recruited a range of participants some of whom were presenting for CBT for the first time. Only three of the intensive participants and two of the weekly participants had an experience of previous CBT. Thus, the views of service users for whom the NICE recommendation is in place are yet to be investigated. This is important, as the views of those who have experienced multiple CBT failures may be different to those undertaking an intensive treatment as their first experience of CBT for OCD.

The aim of the current study was to gain an in-depth understanding from those who have experienced multiple treatment failures on the prospect towards or experience of CBT delivered in an intensive format.

Method

Design

Qualitative methodology was chosen as the most suitable approach for exploring service users' experience of and perspectives on intensive CBT .

Participants and Recruitment

Participants were eligible to participate if they were ≥ 18 years, met diagnostic criteria for OCD (as specified by the Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5) (APA, 2013), identified OCD as their main problem, and reported having had ≥ 2 courses of CBT from which they had an incomplete response. Purposive and snowball sampling techniques were used to recruit participants (Robinson, 2014). Participants were recruited via social media adverts, websites of UK OCD charities, and from attendance at OCD service users' national conferences. All participants who were screened as eligible to take part completed the study.

Measures

Structured Clinical Interview for DSM-5 Disorders (SCID-5) (First, Williams, Karg, & Spitzer, 2015).

To confirm OCD diagnosis, participants were administered the OCD relevant section of the SCID-5, a clinician administered diagnostic interview that is used to determine DSM-5 disorders, reported to have acceptable reliability and validity (First et al., 2015).

Obsessive Compulsive Inventory (OCI) (Foa, Kozak, Salkovskis, Coles, & Amir, 1998).

This 42-item self-report measure assesses severity of OCD symptoms. Items are rated on two five-point (0–4) Likert scales which measure the distress and frequency of each symptom. A total score of 42 or more is indicative of OCD. The OCI has been found to have good reliability and convergent validity (Foa et al., 1998). As is standard, only the total index of distress was used (Cronbach's α = .94).

Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001).

The PHQ-9 is a nine item self-report measure of depressive symptom severity. Each diagnostic criteria for depression is scored from '0' (not at all) to '3' (nearly every day). Total scores range from 0-27; with recommended cuts-offs as follows: 0-4 none or minimal; 5-9 mild; 10-14 moderate; 15-19 moderately severe; 20-27 severe depressive symptoms. The PHQ-9 has been found to be a reliable and valid measure of depression severity, internal

consistency α= .89 (Kroenke et al., 2001). In the current study, internal consistency was α = .96.

General Anxiety Disorder Assessment (GAD-7) (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

The GAD-7 is a seven item self-report measure of generalised anxiety symptom severity. The scale ranges from '0' (not at all) to '3' (nearly every day). Total scores range from 0-21 and recommended cut-offs are as follows: 0-4 minimal; 5-9 mild; 10-14 moderate; 15-21 severe. The GAD-7 has been found to have excellent internal consistency (α = .92), good reliability, as well as criterion, construct, factorial, and procedural validity (Kroenke et al., 2007). Internal consistency in the current study was α = .92.

Work and Social Adjustment Scale (WSAS) (Mundt, Marks, Shear, & Greist, 2002).

This five item self-report measure examines an individual's level of impairment in functioning. The scale ranges from '0' (not at all) to '3' (nearly every day). The scale has good reliability and validity, with internal consistency ranging from α = .70 to α = .94. It has been found to be sensitive to patient differences in disorder severity and treatment related change (Mundt et al., 2002). In the current study, internal consistency was α = .91.

OCD-Self Efficacy Scale (OCD-SES)

The OCD Self Efficacy Scale (OCD-SES) is a 14 item self-report questionnaire adapted from the Hoarding Self Efficacy Questionnaire (Lambe & Salkovskis, 2015), which had reasonable internal consistency (α = .67) and was developed in line with Bandura's (2006) guidelines for developing self-efficacy measures. The OCD-SES contains 11 items that explore individual's beliefs in their perceived current capacity and ability to exert control over their OCD and three items regarding their mid to long term confidence. Items represent tasks required for an individual to overcome OCD (e.g. 'resist the urge to respond to my OCD'). For each statement participants are asked to rate how confident they are on a scale from '0' (no confidence) to '100' (completely confident). In the current study only the 11 items pertaining to participants current perceived efficacy were used. The internal consistency was excellent (α = .94).

Qualitative Interviews[11]

A semi-structured interview was developed by two clinical psychologists (JM & PM) who work at a national centre of excellence for the treatment of OCD, in collaboration with an individual with personal experience of both weekly and intensive CBT for OCD. Questions started by asking participants to talk about previous experiences of CBT and to describe the delivery of therapy they had previously undertaken. Participants were asked about what aspects they found most helpful or potentially unhelpful. Participants were then provided with a definition of intensive CBT. Intensive CBT was defined as 12-20 hours of CBT delivered on two or three days each week over a three-week period, with three booster sessions offered once a month post therapy. Participants who had not experienced intensive CBT were asked about their views on the prospect of receiving CBT in this format. For participants who had an experience of intensive CBT, they were asked about their experience of this treatment. The semi-structured interview was piloted with a person with personal experience of OCD who had not experienced intensive CBT. In response to the pilot interview additional optional prompts were added. During the interview the researcher encouraged participants to elaborate on their answers, provided prompts and sought clarification where necessary. Participants were invited to ask questions throughout the interview and on its conclusion.

Procedure

Ethical approval was granted by the University of Bath Research Ethics Committee (17-304). Participants who expressed an interest in participating were contacted by phone to discuss the study and their eligibility. If inclusion criteria were met, participants were emailed a link that directed them to an online questionnaire portal. Participants were asked to read an information sheet and informed consent was obtained via an online consent form. Participants were then asked to complete the series of questionnaires. A time for the interview was then scheduled. Individual interviews were conducted by telephone and lasted approximately 60 minutes (range 24 - 100 minutes). Interviews were recorded using a digital voice recorder and were transcribed verbatim, with identifying information removed and pseudonyms inserted. If participants requested further support, they were signposted to appropriate resources. On completion participants received a £5 electronic voucher in appreciation for their time.

[11] The semi-structured interview schedule is available from the corresponding author on request.

Data analytic strategy and approach

The data set comprised 30 completed questionnaire batteries and 30 transcribed interviews. Descriptive statistics were used to summarise clinical characteristics of the sample and reports of previous CBT. Transcripts were analysed using thematic analysis (TA), as described by Braun and Clarke (2006; 2013). TA is well suited to exploring individual's experiences and how they make sense of them and was chosen to enable patterns and themes to be derived from the data. The six-phase process was followed (Braun & Clarke, 2006; 2013). The first author familiarised themselves with the data via reading of transcripts thoroughly. Transcripts were then systematically coded. The data were approached from a critical realist perspective, which assumes that the data represent a valid report of the participant's reality, explained by the way in which the participant talks about their experiences and the meaning this has for them. The analysis was primarily conducted by the first author, a clinical psychologist experienced in the treatment of OCD. An inductive approach was utilised, meaning that the data was the starting point for analysis rather than applying pre-existing theories to the data. However, the author's clinical and academic knowledge is likely to have influenced the analysis and therefore to some extent a deductive approach is incorporated. Codes were arranged utilising a thematic map to identify initial candidate themes. Another researcher also coded a proportion of the transcripts (n = 15) and identified potential themes. The first author and this second reviewer met to discuss the codes, candidate themes, associated interpretations and the thematic map. From this discussion and subsequent discussions with co-authors, the overarching and subthemes were refined and finalised.

Results

Participants

To contextualise the sample, a demographic summary of participants' characteristics, treatment history and symptom severity is presented in Table 1. The trajectory of participants' age of OCD onset and the significant delay in receiving treatment for OCD is consistent with the literature (Fineberg et al., 2019). One third of the sample had experienced an intensive format of CBT. Symptom severity measures indicated that participants on average were experiencing moderate to severe OCD, mild to moderate depression, mild symptoms of generalised anxiety and significant functional impairment. However, as measured by the self-efficacy scale participants expressed a moderately high level of confidence that they would be able to overcome their OCD.

Table 1.

Participant characteristics, treatment history and symptom severity

Participant Characteristics		
Demographics		***N (%)***
Gender	Male	8 (26.7)
	Female	22 (73.3)
Ethnicity	Asian & Black African	2 (6.6)
	White	28 (93.3)
Education	GCSE or equivalent	3 (10)
	A level or equivalent	3 (10)
	Diploma	1 (3.3)
	Undergraduate degree	13 (43.3)
	Postgraduate degree	10 (33.3)
Employment	Unemployed (available for work)	1 (3.3)
	Sickness Benefits	6 (20)
	Student	1 (3.3)
	Employed part time	5 (16.6)
	Employed Full time	12 (40)
	Other (carer, retired)	5 (16.7)
		***M* (*SD*)**
Current Age		39.47 (11.81)
Symptom Severity	OCI	52.67 (37.58)
	PHQ-9	9.23 (9.15)
	GAD-7	8.93 (6.15)
	WSAS	17.43 (11.81)
	OCD-SES	79.70 (21.10)
History of OCD & treatment		***M (SD)* years**
Duration of OCD		26.8 (12.19)
Age of onset		12.67 (7.57)
Age significantly interfered with life		16.6 (7.79)
Age found out that problem was OCD		20.56 (8.88)
Age first diagnosed with OCD		28.63 (11.40)
Age first sought help		26.3 (11.74)
Age first offered treatment for OCD		29.37 (12.02)
		***Mdn* (Range)**
Number of past sets of therapy		3 (2-10)
Number of past sets of CBT		3 (3-8)
Experience of treatment formats		***N (%)***
Experience of weekly CBT only		20 (66.6)
Experience of Intensive CBT		10 (33.3)

GAD -7 = Generalised Anxiety Disorder; *M* = Mean; *N* = Number of participants; OCD-Self Efficacy Scale = OCD-SES; OCI = Obsessive Compulsive Inventory (Distress); PHQ-9 = Patient Health Questionnaire; *SD* = Standard deviation; WSAS = Work and Social Adjustment Scale.

Qualitative Analysis

The analysis of participants' experiences and views on intensive CBT identified four overarching themes: 1) *Continuity and Momentum*, 2) *Hmm, yes, but…: reservations about intensive CBT,* 3) *The fortune is in the follow-up* and 4) *Understanding individual preference*. These are shown with sub-themes and headings in Appendix 1.

Overarching Theme 1: Continuity and Momentum

This theme captured participants' narratives on the aspects of the therapeutic process that are perceived to be influenced by the continuity and momentum that result from an intensive format. It focused on participants' perceptions of how longer sessions could be used and described gains that were perceived to likely as a result. This theme comprised four subthemes; 1) *Therapeutic flow and engagement*, 2) *"The therapy that gave me wings": In-session ERP*, 3) *Big, fast, gains,* and 4) *Clearing the decks for success*.

Subtheme 1.1: Therapeutic flow and engagement.

The concept of intensive CBT facilitating greater continuity within treatment featured strongly for all participants. Participants contrasted this idea with experiences of weekly treatment, where shorter session durations had, at times, been perceived as an interruption.

> *You might've been in a moment […] where you felt like you really wanted to carry on talking about it some more, because you felt like there were things you needed to explore, because of the fact that it's an hour you haven't been able to do that as much as you wanted to. Or as much as what your therapist might have thought would be useful (Karina, x 3 weekly).*

For some participants the passage of time in-between sessions was construed to have an undesirable diluting effect on their ability to recall important elements of previous sessions.

> *As hard as you try, when you come back to it a week later, it's very difficult to then get yourself back into that frame of mind, where you think, you know, about this particular obsession, or difficult to remember what you sort of said about it (Leticia, x 3 weekly).*

Participants also suggested that longer sessions would be advantageous for the purpose of allowing enough time for making sense of their intrusive thoughts/ images. This was discussed by some participants as being a fundamental but challenging part of therapy, better facilitated by a single longer session.

> *The therapist needs time to be able to question where that thought is coming from, "what does that mean?", "So what would that mean if it was dirty?" That took about three hours to get down to realising what was driving my thoughts and if that had been broken up into three weeks, I'm fairly certain I wouldn't have got that conclusion about myself, because I would have broken that train of thought. You lose that focus of that moment on drilling down on something (Harper, x 3 weekly, x 2 intensive).*

Furthermore, homework tasks were constructed as important to therapeutic progress and participants' narratives evidenced their desire to undertake such tasks. However, participants contrasted this theoretical benefit with the difficulties of utilising the time in-between sessions as intended.

> *On one hand it's really good to have it weekly, because you keep on top of it [...] have the time [to] practice […]. At the end of a session, I'd be like "yep, I'm going to tackle that", but then often what I'd find is that in-between sessions I'd sort of forget about it […] get distracted by other things (Sophia, x 3 weekly).*

Participants who had not undertaken intensive CBT perceived the intensive format to have the potential to provide a scaffolding that would facilitate the tackling of tasks that were difficult to undertake alone. Participants promoted the idea that longer sessions would facilitate increased engagement.

> *Doing it all in one block would just be very helpful […] I think when it's week by week, you kind of go away and sort of, you might not always, put into practice what you've learnt[…] and it would make you more inclined to actually do it as well, if you've got to go back week after week and you're sort of ruminating about it, you might not go back the next week, so I think that that would be very, very, very effective for someone like me (Allie, x 3 weekly).*

Participants who had undertaken intensive CBT described engaging with aspects of therapy in session that they had been previously avoiding.

> *It [ERP] was actually there and then and there was no, like, building up to it; there was no escaping it, you know it was like, you're there, you're doing it, because before I was having the sessions then going away and being in my own head for a week, just basically arguing with myself, but with this [intensive] I was actually doing the hard stuff (Keryn, x 3 weekly, 1 intensive).*

Participants who had not experienced intensive CBT proposed that greater continuity in treatment would result in the building of momentum, focus and potentially facilitate better outcomes.

> *It may be that by having it constant, today and tomorrow and tomorrow, won't give the emotional brain [a] chance to slacken off and go back down into a lull period, then psych back up. For the exposure to be happening you wouldn't have a chance to be, "oh that's over with, I've got a whole week now to think about It". Whereas if it was going to be tomorrow, maybe that level of exposure would have had a different outcome (Gary, x 3 weekly).*

Participants with experience of intensive CBT, mirrored expectations of those who had not, by reporting the notion of successful momentum building.

> *I think the intensive is really important because you need that momentum, I really feel you need that momentum to really make strides (Max x 2 weekly, 1 intensive).*

In summary, both participants with and without an experience of intensive CBT described intensive CBT to facilitate greater engagement as a result of the continuity and momentum of an intensive approach.

Subtheme 1.2: "The therapy that gave me wings": In-session ERP.

This subtheme captured participants' views on intensive CBT encompassing longer sessions and this facilitating time for in-session ERP to be undertaken. Participants who had not undertaken intensive CBT speculated that a consequence of longer sessions would be the inclusion of in-session ERP and/ or BE. Participants reported that this would be desirable for two key reasons; firstly, it would provide the opportunity for the therapist to model the theory of what they were asking patients to do.

You're talking about it all in the office and you're like, "Yeah I can do this." Then as soon as you leave the office, you've got to do it for real […] if you've got more time, that maybe they [therapist] could actually do it with you in the office. Just start it off, kind of reinforce what you actually need to do (Ethan, x 3 weekly).

Secondly, participants described that an intensive format would allow for experiential learning to occur in sessions. Participants described that longer session times would enable them to try out how the therapy worked whilst in a supported environment. This was perceived to foster the likelihood of ERP continuing outside of the session.

So instead of saying, "here's what we want you to do this week", you could actually perhaps put it into practice during the session, so you know it works. Then you've already kind of got experience of it and probably more likely to try it out on your own (Jeremy, x 3 weekly).

Participants with experience of intensive CBT described therapy sessions where the time had been used to focus on undertaking ERP in environments specific to their OCD. Participants described the therapist involvement as important and valuable.

The therapy that gave me my wings was intensive. The exposures were clinically supported; so, I went out in situ in hospitals, and touching sinks and public phone boxes, and buying things from people with cuts on their hands; all with a clinician (Janice, x 2 weekly, x 1 intensive).

A prominent thread from those who had undertaken intensive CBT was the importance of sessions being long enough to allow the therapist to complete the ERP session with the patient. The extended session time was constructed as a facilitator of enabling the patient to feel secure enough to take the leap-of-faith required. This belief was underpinned by participants' experiences of what they had previously lost as a direct consequence of their OCD (e.g. losing one's home, savings etc.).

The number one thing is having the right support and having the right support in therapy. I think that is a big thing for me and I'd imagine for a lot of people, cause the reason you can't do the exposure on your own is cause you feel you can't do the exposing. It is to know that the person with you isn't going to leave you, until you're okay. That was key for me (Harper, x 3 weekly, x 2 intensive).

Participants with experience of intensive CBT also described the importance of the 'extremes' to which ERP/ BE needed to be taken to be effective (i.e. anti-obsessional tasks). The longer session was again construed as a facilitator of this.

> *What made the difference I think, was that it was anti-obsessional; so, doing things that nobody would do on the normal spectrum of things […] It was putting your hand into the toilet water and then not washing and touching things in the flat, including things that you couldn't wash, including inside the fridge and all the kitchen utensils (Sharon, x2 weekly, x 1 intensive).*

Overall a key benefit of the intensive approach was perceived to be the longer session time which was viewed as key for facilitating in-session therapist assisted and supported ERP. The in-session ERP was perceived as important for learning how OCD works and for instilling participants' confidence in tackling their OCD.

Subtheme 1.3: Big, fast, gains.

Participants with experience of intensive CBT described the rapid pace at which gains had occurred. This included taking action against OCD that was perceived to occur more quickly than expected, or in comparison to their experiences of weekly CBT.

> *Yeah, the two intensive days, they were like ten till four, ten till three, I can't remember the exact times, but that really kicked me into action to do that. Doing stuff that I thought would have been way down the track (Amber, x 2 weekly, x 1 intensive).*

The concept of increased self-confidence as a consequence of fast gains also featured strongly for these participants. Participants reported that as they started to tackle their OCD successfully in session, their confidence in their ability to continue to make progress increased.

> *I think you really need to do the intensive go out and do the stuff you don't want to do or whatever it is. I think that gets the ball rolling and it builds confidence quickly […] I think it does start to have an immediate impact in a very short and quick time (Harper, x 3 weekly, x 2 intensive).*

Participants spoke about the impetus for choosing to change, describing the significant discoveries that had occurred during an intensive session with the realisation of what worked and how they could maintain their gains.

All the agonising, and the intensive fear, was all before it, like months and months before it, and the night before it. Then we did it [intensive] […]. So that was big. You could see the graphs; handwashing plummeted, and the showering plummeted, from that day after the intensive. The next few days, I thought, "Well, if this is what it takes to keep this OCD away, then I'll do it every day". So, I was doing it every day. (Sharon, x2 weekly, x 1 intensive).

Overall, the gains reported related to taking action in therapy quickly, which resulted in increased confidence and continuing to use ERP after treatment to maintain gains.

Subtheme 1.4: Clearing the decks for success

This subtheme captures participants' narratives around what they perceive is required to successfully participate in intensive CBT. Participants described a high level of preparation and commitment and the attitude deemed necessary to maximise potential benefits. Participant narratives described the commitment as one that not only affected the individual undertaking the CBT but was something requiring consensus and priority within the family unit.

As a family, we'd had to block out time for my recovery. Just like if someone was going for an intensive driving course; you change your world because you're going to go for two weeks, learn to drive. Or the child that goes for intensive swimming lessons two times a day for three weeks, and they can swim. It was a family decision to make sure that child gets […] It was exactly the same in this house, it was a family decision that we were going to change our world to allow for intensive treatment of OCD. Everything was set up for my recovery; even down to what dinners we ate. The only thing I had to do was my homework, we cleared the decks for my recovery. There was a commitment that came over and above what it was for the weekly (Janice, x 2 weekly, x 1 intensive).

Participants were keen to highlight that in order to undertaken intensive CBT it was necessary to plan ahead to ensure sufficient time is scheduled for the treatment.

You've got to want to do it [undertake CBT] and actually, you've got to carve out the time to do it [intensive CBT] (Tina, x 5 weekly, x 2 intensive).

Participants reported that in order to maximise gains, it was important to focus on and engage with therapy as fully as possible as soon as it had commenced.

> *I found the intensive really good because it was like jump starting everything, it was just going all in, right from the start and it was just kind of push, push, push until the end (Keryn, x 3 weekly, x 1 intensive).*

Participants noted the importance of integrating ERP into their life in-between the intensive treatment sessions, again with the aim of maximising gains.

> *The therapy is several hours twice a week […] and then the rest of time you're doing stuff […] and you get out what you put in. So, if you can treat it like a full-time job, the better for you (Max, x 3 weekly, x 1 intensive).*

Some participant's narratives alluded to intensive treatment being viewed as a last resort, requiring maximum dedication. Participants prefaced that getting to the point of being offered intensive treatment had been a long and difficult process.

> *It needs to become the new way of life and the only way you can do that is by focusing on it. […] obviously you must carry on with normal life, but I have to be the focus for a period of time (Harper, x 3 weekly, x 2 intensive).*

Overall the narratives of participants with experience of intensive CBT, was one of being motivated and ready to engage, and consequently directing all of their focus and resources to maximising the outcome of treatment.

Overarching Theme 2: Hmm, yes, but...: reservations about intensive CBT

This theme captured participants' narratives around reservations they held regarding an intensive format. Participants described aspects of the intensive process they perceived would make it difficult or potentially unsuitable. Participants also described factors relevant to the intensive process they perceived would need to be addressed. Three subthemes were identified 1) *Too intense*, 2) "*Can I trust you?": The importance of therapeutic alliance* and 3) *Slap bang, crash and burn*: *Relapse after intensive CBT.*

Subtheme 2.1: Too intense.

Participants discussed that an intensive approach may not be appropriate for everyone. Participants fell into one of two groups; first, those participants who identified that for 'others' intensive CBT may be too intensive, suggesting it may be emotionally

overwhelming or exhausting. However, these participants did not anticipate, or had not experienced this to be the case for themselves.

> *Well, I guess it might be emotionally quite exhausting on somebody, so that might be problematic. It might be addressing, sort of, lots of different issues all at once, [it] might be a bit overloading. But for me, I would quite like that. I think I would like to get it all out the way (Semone, x 3 weekly).*

The second group personally identified with the idea of intensive treatment being too difficult to undertake. Three main reasons were identified. Firstly, participants expressed the idea that undertaking intensive CBT would be *emotionally taxing or overwhelming* due to the extended time that they would need to endure anxiety within the treatment session.

> *I have a pretty low threshold for the anxiety I could take […] thinking about what I could handle at the moment (Alicia, x 8 weekly).*

> *I think to do CBT and or exposure response for two or three hours at a time would be exhausting (Leticia, x 3 weekly)*

Secondly, some participants identified that having the *diagnosis of OCD* itself *or* additional *comorbidities*, would preclude them from intensive CBT. These participants held the belief that because of their difficulties their capacity to meaningfully engage in therapy for an extended period was reduced. These participants expressed the belief that a slower pace of therapy was important in the treatment of OCD.

> *I think for anybody who has dealt with mental health issues to go in for two or three hours, would be extremely taxing, but for someone with OCD […] I think your mind can only handle so much at one period. I think with OCD you actually have to go slow […] You can't cram that much into one session because it's ineffective after an hour or so (Joy, x 3 weekly).*

Participants also discussed the broader impact, disability and damage that had occurred in their life as a result of their OCD and related comorbidities. This was perceived by some participants as indicative of therapy requiring a longer passage of time.

> *I needed that time to go away and process it […] I had so much work to do and it took time to chip away at a lot of the things […] A lot of the collateral damage, I*

suppose, and a lot of the stuff to do with my depression and my self-esteem too (Beth, x 5 weekly).

Thirdly, participants identified CBT as comprising a *large amount of content.* Participants anticipated that they would need a longer period of time to process this and cope with the demands of therapy.

It would've probably pushed me over the edge a bit. I think there's so much content to kind of get your head around and then to apply to yourself, that I think for me personally there needed to be that breathing space in between of a week to integrate (Polly, x 4 weekly).

Overall participants who had not experienced intensive treatment were divided in their views. Some participants viewed intensive treatment as difficult due to the likely emotional impact, their OCD and associated comorbidities and quantity of CBT content. However, while other participants acknowledge these possibilities, most believed these restrictions would not apply to themselves.

Subtheme 2.2: "Can I trust you?" : **The importance of therapeutic alliance.**

Here, participants emphasised that whilst the therapeutic relationship is essential for the success of therapy regardless of delivery format, it is particularly crucial for intensive CBT. This notion was underpinned by the level of trust participants conveyed is required for undertake intensive CBT.

It's very dependent on your therapist, who you've got as a therapist […] I think that therapeutic relationship is really important, I'd be thinking "can I trust you?" […] it's got to be somebody you get on with, you trust, and you respond to, and […] they understand the problem (Genevieve, x 2 weekly, x 1 intensive).

The amount of time participants perceived it would take to build the trust required to participate in intensive CBT varied, ranging from a short to an extended period. Some participants described establishing trust, rapport and an effective therapeutic alliance with their therapist very quickly.

I was really, sort of, blown away, in a way by her belief in me and I think that was something that I'll always remember, her, her just belief right from the start (Janice, x 2 weekly, x 1 intensive).

The relationship between you and your therapist is really important, like with the various different episodes of CBT that I've had, I've always found that I've been able to build up a really good rapport with my therapist at the start, because they've always been really skilled [..] known the subject matter really well […] warm and empathetic (Kasia, x 4 weekly).

Others participants described requiring a significant time to trust both the therapist and the therapy they were delivering.

I would say probably 80% of the total change happened on those two [intensive] days. However, I would not have been able to get to them without the trust-building with the therapist as a person, and the building trust, very slowly, in the method, and the theory. A lot of that was done in the traditional office-based sessions for one hour, and a bit of thinking time in between. My main concern at the time would have been that I couldn't trust the person enough […]. There was a lot of pushing, in a positive way, from my therapist (Sharon, x 2 weekly, x 1 intensive).

Within this subtheme it was unanimous that the therapeutic relationship is essential. Variation only occurred with regards to the length of time anticipated to establish this.

Subtheme 2.3: Slap bang, crash and burn: Relapse after intensive CBT.

Participants who had not experienced intensive CBT reflected on the possibility of relapse occurring more quickly after intensive CBT. Participants expressed concern that as therapy would occur over a shorter period, there may not be a sufficient period of time for everyday life to occur and for obstacles to be addressed within therapy.

Knowing what I know now, for me personally, I think intensive would have worked really, really well, but then I wonder if I would have relapsed quicker because I had no time to do those things on my own (Gavin, x 3 weekly).

Some participants described with an element of certainty that if intensive CBT was delivered and then ceased without follow-up, then relapse was likely.

If you just did the intensive weeks and then it stopped, you're then left completely alone to do any of the homework that you need to do. I think you definitely, without a doubt, [would] relapse. I think if it was slap bang, here's two weeks, and then go away and get on with it yourself, I don't think it would work (Cooper, x 3 weekly).

I've done some intensive treatment in [location] where I meet with somebody every day during the week […] I've done that a couple of times and it has shifted things, but I've never been able to keep it going for very long (Natalie, x 4 weekly, x 2 intensive).

Some participants perceived they had 'further to fall', with gains made in intensive CBT. This was suggested to be caused by therapy coming to an end and there being no provision of follow-up on completion.

You can make progress fast, but, […] once the stabilisers are off, and you're on your own you can crash and burn and fall back, and when you fall back, I think you fall further than you expect (Hunter, x 2 weekly, x 1 intensive).

Overall participants described concerns with relapse or the experience of it, attributing this to the lack of provision in follow-up after the formal part of intensive CBT had concluded.

Overarching Theme 3: The Fortune is in the follow-up

This theme captured participants' narratives around the importance of follow-up after completion of therapy and featured strongly within the sample. All participants discussed issues related to follow-up regardless of whether they had undertaken intensive CBT. There was a unified construction of follow-up as an essential and highly desirable component of therapy that was rarely available or offered to participants. No subthemes were identified here, but six headings that discern different aspects of the theme are denoted in bold italics.

Participants' narratives reinforced the idea that gains made in intensive therapy were likely to only be maintained with ***appropriate follow-up***.

I think after that initial three or four weeks of intensive you probably need to stay in touch with your therapist for at least six months. I don't think this is something that you're going to get rid of in a month without continued support (Gary, x 3 weekly).

Some participants highlighted the perceived usefulness of follow-up in the form of ***booster sessions***. Participants described how these sessions could be used to address obstacles that had arisen since the completion of therapy and thus resolve any issues to ensure the participant is kept on track.

With those booster sessions, say something happened today, I can write that down and I can come in […] unpack it with therapist and they might say, "Go away now

and do lick that bin and roll around in it", and that might actually help you for the next time that something happens around a bin. Whereas if you haven't got that check in, and something happens that you don't cope with, you're just left feeling like a failure and that's when things can all start to go wrong (Harper, x 3 weekly, x 2 intensive).

Participants highlighted the idea that sufficient follow-up need not be time consuming, suggesting it was more the act of reinforcing what had been learned and achieved.

Some sort of follow-up for people who have [been] discharged from services, just to see how they're doing to kind of really reinforce the CBT model would be quite helpful and I don't think it [has to be] that time consuming (Ethan, x 3 weekly).

Participants suggested the use of communication/ messaging ***technology*** as a viable alternative to face-to-face follow-up, reiterating the idea that follow-up could be relatively minimal.

Some form of checking in with your therapist, whether that be through a phone call or Skype or through an app […] It doesn't have to be huge long sessions, but I think you do need to check-in with them (Gavin, x 3 weekly).

There was a strong narrative around the possibility of other ***allied health professionals*** who are "CBT literate" potentially providing follow-up. Participants were keen to demonstrate their awareness of the higher costs of psychologists and OCD specialists and to think laterally about other ways in which continuity in care could be provided.

In terms of having somebody CBT-literate support me; it wouldn't necessarily need to be the same therapist as long as they know OCD, it could be someone in training, or another background (Leticia, x 3 weekly).

Emphasis was placed on the ideal form of follow-up being ***flexible and responsive to needs***, seeing decreased frequency when patients were doing well.

I think a year would be good, a year from when the intensive treatment ends […] Being able to check in, having somebody flexible, who might say, "You are doing reasonably well; let's not meet for a month", or, "You're really struggling; let's meet on a weekly basis". Not having it open-ended, because that means you can end up procrastinating, but not having that, "OK, the money has run out" limit either (Sophia, x 3 weekly).

Frequently discussed was the premise of the patient's file being "kept open" by the treating service after the patient had been formally discharged. This idea was premised as a potential way of supporting ongoing follow-up where needed, and preventing difficulties encountered with re-referral.

> *Stuff just does come up and to be able to know, you've got somewhere to go, where you're not going to have to re-explain your history, where somebody gets the problem (Harper, x 3 weekly, x 2 intensive).*

> *I was amazed when I heard about that trust [that keeps patient files open after discharge], and the person who told me about it said it made a lot of difference to them (Joy, x 3 weekly).*

Participants constructed arguments around the disparity in provision of follow-up for physical health in comparison to mental health problems. Physical health problems were constructed as socially acceptable with the individual suffering perceived not to be at fault and thus the process of recovery unquestionably requiring follow-up. However, for mental health problems a different set of rules were perceived to apply. The onus was perceived to be on the individual to be completely well at the designated end of the treatment with no follow-up necessary. Participants also alluded to the economic costs involved in not providing appropriate follow-up.

> *I know they say the NHS is completely overflowing […], but I just don't get why it's completely standard you know, for physical health problems, you just wouldn't see it [the absence of follow-up] with a physical health problem. You'd get your treatment […] then the specialist would say "now come back and see me in a month" or two months and if you're doing fine you might come back in a year. But no, not if it's for mental health, you gotta fight […], surely follow-up would save [NHS] a fortune in the end (Cooper, x 3 weekly).*

Overall, participants described a range of different models of follow-up in terms of duration, provision and mode of delivery, with the bottom line being a consensus that follow-up should be a routine part of care.

Overarching Theme 4: Understanding Individual Preference

This theme captured factors specific to the individual that participants perceived as important in influencing their preference for treatment format. Three subthemes were identified, these include: 1) *Failing made me ready*, 2) *Patient choice, circumstance and severity* and 3) *The best of both worlds*.

Subtheme 4.1: Failing made me ready.

Some participants described previous experiences of undertaking weekly treatment as influencing their preference for an intensive version of treatment.

> *I trusted, obviously, what she was saying even though it felt frightening. And I had the advantage of having CBT a few times before so at least I'd had that foundation. (Amber, x 2 weekly, x 1 intensive).*

Similarly, participants reported that due to a series of previous unsuccessful courses of weekly CBT, they were keen to undertake a different format of therapy.

> *Because I've gone down these routes of therapy that's been spread out over all these weeks and it's not worked, then I'm thinking there needs to be an alternative (Nadia, x 8 weekly).*

Some participants equated an intensive version of CBT with its provision by a specialist therapist. This suggested that participants perceived intensive CBT to be a specialist treatment and some attributed aspects of their previous CBT as unsuccessful due to a deficit in previous therapist's skills.

> *In a nutshell, a highly trained OCD professional with an intensive course of therapy rather than a therapist that isn't an OCD specialist over a period of weeks, because that hasn't worked. The idea and the concept of CBT is right, and I think it works. It's what we need. It just needs to be much more intensive (Jeremy, x 3 weekly).*

Overall participants' experience of previous CBT was perceived as an important factor in influencing their preference for intensive CBT. It was constructed as a part of the potential for CBT to be successful as it would be undertaken in a different format.

Subtheme 4.2: Patient choice, circumstance and severity.

This subtheme captured participants' preferences for treatment based on three criteria. The first relates to service user choice. Several participants suggested that people

should be provided with information on different treatment options and be able to contribute to discussions around which might suit them best.

> *It's giving people choice, but also giving people information about what other people's experiences have been (Sharon, x 2 weekly, x 1 intensive).*

Secondly, participants discussed practical and logistical factors likely to be important when determining if an intensive format is preferable.

> *I think it's going to depend on the person and what they've got going on in their lives […] whether it's easier for them to take three weeks off work and just get it done. (Penny, x 6 weekly).*

> *The only thing about weekly was it was easy to fit around the rest of my life. Actually, finding the time when people are working, might be difficult. Or if they had childcare duties or things like that (Semone, x 3 weekly).*

Thirdly, some participants constructed their preference based on the severity of their OCD. These participants perceived that due to their OCD being very severe the only format of treatment likely to help was intensive.

> *I think once it's really got severe, like mine is, […] you need the intensive stuff because if you just do an hour and then go away, it's not actually going to make any inroad into it (Natalie, 4 weekly, x 2 intensive).*

Some participants described how the longstanding nature of their OCD meant their symptoms had become entrenched. Thus, intensive CBT was the only format likely to prove helpful.

> *Like a lot of us, I've had OCD for the best part of 30 odd years and to get out of that behaviour and that way of thinking that's so ingrained in you, you do need a big hit of therapy all in one go. I think the more condensed and full-on the better (Nadia, x 8 weekly).*

Other participants positioned intensive CBT as the most viable option due to the level of disability they were experiencing as a result of their OCD, for instance inability to work.

> *Now that I can't work, I can almost devote, if you like, every moment of every day to working on my OCD. I'm beginning to realise that this is something that has to be worked on 24/7 to get anywhere (Jeremy, x 3 weekly).*

Several participants expressed concern regarding resource limitations with regards to accessing intensive CBT on an outpatient basis. Participants suggested that intensive CBT should be more easily accessible and not only obtainable on an inpatient basis.

> *To get in-patient, which I would say is the closest thing to intensive that is more widely available, you have to surrender completely. Lose your job […] leave family behind, young children […]. It's a massive thing. […] Even when we were living in a hotel driving around at night wondering what hotel to check in to that isn't contaminated. I still couldn't bring myself to do that. But, it [intensive] shouldn't be a type of care that's limited only to people who are doing that [inpatient admission]. That same level of care should be available to people who are able to carry on a little in their day to day life (Harper, x 3 weekly, x 2 intensive).*

Overall, participants described a range of factors that they perceived as relevant to their preference for format of treatment. Underlying these preferences was the concept that patients should be able to express their preference and that intensive CBT is a desired outpatient care option.

Subtheme 4.3: The best of both worlds.

Participants frequently constructed an ideal format of therapy, consisting of combination of intensive and weekly sessions.

> *I wouldn't want one or the other because I think the intensive got you up to speed, rather than the information being drip fed over the weeks, and then the weekly you link it all together (Amber, x 2 weekly, x 1 intensive).*

However, participants varied in their views on the order or the combination of treatment format they would desire. Some participants expressed a preference for beginning treatment with intensive sessions, others suggested a mixed approach.

> *An intensive burst, but then with continuing support with less intensity would probably be the best […] for maybe eight weeks, an hour a week and then just checking in (Jeremy, x 3 weekly).*

> *An ideal scenario I would say, a couple of weeks where you had weekly, then maybe at least two or three [intensive sessions] a week, for a couple of weeks, and then go back to weekly for at least two or three months. Then go [to] catch up sessions (Genevieve, x 2 weekly, x 1 intensive).*

In my last CBT, I had twenty weeks straight […] some longer sessions would have been helpful. A couple of those being 1.5 to 2 hours long, spacing the later sessions out (Sophia, x 3 weekly).

There was clear agreement across the sample that treatment should not finish abruptly. Phasing out of sessions was a strong preference and perceived to allow incorporation of gains made and management of future obstacles.

A really good combination […] we started seeing each other weekly and then she was away […] so it went down to two weekly, and we thought, "shall we keep it like this?" Then it went down to monthly, then to six weekly […] this meant that I saw [therapist] for just shy of a year right. Which meant that it gave me so much more time to go out, to do the homework, to live my life, but to still know that I had that psychological safety net of [therapist] (Penny, x 6 weekly).

Overall, there was not a consensus on the preference of how an intensive treatment should be delivered. However, a proportion of participants recognised the benefits of both formats and suggested different hybrids of the treatment as preferable.

Discussion

The main purpose of this study was to provide an in-depth examination of how people view and experience intensive CBT. This was done from the perspective of OCD participants who had experienced multiple CBT failures. The results brought forward key factors that participants perceived would be accommodated by an intensive format that had been missing or not covered sufficiently in their previous experiences of weekly CBT. These factors fell under four overarching themes. They encompassed perceptions on the process and utilisation of intensive sessions, along with the gains both anticipated and actualised, and the mind set required to undertake intensive CBT (Theme 1: *Continuity and momentum*). While advantages to the intensive format were identified, there were caveats. Reservations identified as relevant to an intensive approach (Theme 2: *Hmm, yes, but…reservations about intensive CBT*), as well as the perceived follow-up required (Theme 3: *The fortune is in the follow-up*), and factors specific to the individual that influence format preference (Theme 4: *Understanding individual preference*) were all key. Most themes were shared by participants with or without an experience of intensive CBT, the only exception being the subtheme of 'Big, fast gains' which was specific to those with a lived experience of intensive CBT.

The first overarching theme, focused on continuity and momentum, was consistent with many issues identified from the perspective of the patient with regards to treatment

failure (Millar et al., in prep). Participants brought forward aspects that they were dissatisfied with from their weekly format treatment (e.g. lack of time for in-session ERP), describing the intensive format as a possible solution for the identified difficulties (Millar et al., in prep). Participants identified having longer sessions as a potential benefit in maximizing the therapy continuity and momentum seen as lost between weekly sessions. They also viewed the intensive format as a solution to the previous experience of inadequate therapist assisted ERP and the likelihood of increased progress. For many patients, undertaking ERP is a daunting prospect and even more so on one's own (Kozak & Coles, 2005). The opportunity to utilise longer sessions to try out both 'therapist directed' and then 'self-directed' ERP (Tolin & Hannan, 2005) makes practical sense, and is supported by outcome research as superior (Tolin et al., 2007).

Some participants perceived their OCD diagnosis and associated comorbidities to preclude them from an intensive approach. OCD is found to have high rates of comorbidities, particularly with depression (Abramowitz, 2004). In an intensive version of Cognitive Therapy for Post-Traumatic Stress Disorder, Ehlers and colleagues (2010) found that the intensive format led to greater reductions in comorbid depressive symptoms, which were maintained throughout the follow-up period. It is possible that an intensive version of CBT for OCD could bring secondary benefits for participants with comorbid depression, further enquiry is required. Nonetheless, this has not been tested in the OCD field, and patient perceptions relating to the suitability of intensive CBT for more complex cases may need to be overcome.

Some participants expressed concern about the intensive format being too intense. Interestingly, the majority of participants expressed concerns that the approach could potentially be too intense for others; however, they did not perceive this as applying to themselves. Bevan, Oldfield & Salkovskis (2010) qualitatively examined the experience of participants who had chosen to undertake an intensive version of CBT or had been allocated to undertake weekly CBT. They found that those who had undertaken weekly CBT expressed a similar view regarding intensive CBT potentially being too intense or overwhelming. However, those who had undertaken intensive CBT did not hold this view, instead perceiving their experience as powerful, motivating and useful for overcoming avoidance. The importance of establishing an effective therapeutic alliance was emphasised in both the current and Bevan et al. (2010) study. In the current study, longer session time was perceived as being useful for 'making sense' of the problem and understanding 'meaning' as well as facilitating faster and larger gains. The use of collaborative case

formulation early in the treatment of OCD has been found to reduce patient distress and improve therapeutic alliance (Nattrass, Kellett, Hardy, & Ricketts, 2015).

The importance of follow-up sessions for ongoing support and relapse prevention, was raised by all participants. Participants reported that follow-up was consistently not adequately provided in the context of weekly CBT. However, follow-up was emphasised to be of particular importance to intensive CBT. This finding is consistent with the reports of participants who had previously undertaken intensive CBT (Bevan et al., 2010). NICE (2005, 2018) recommend that follow-up be provided for up to 12-months following intensive treatment. However, the extent to which this recommendation is followed in practice is unknown and requires investigation. In general, there is a dearth of literature pertaining to the importance of follow-up sessions.

As a by-product of acknowledging the cost of therapist led follow-up, participants suggested that innovative methods be considered. One suggestion was the use of communication technologies. Although interventions in the form of Computerised CBT (cCBT) are now being trialled for a range of mental health conditions (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Menon, Rajan, & Sarkar, 2017; Tang & Kreindler, 2017), providing follow-up or relapse prevention has not been a focus of this medium. However, this approach has been utilised as a relapse prevention method to maintain smoking abstinence in individuals with Post Traumatic Stress Disorder, with promising preliminary results (Hicks et al., 2017). Utilising a low intensity follow-up intervention would be consistent with a 'stepped care' approach. However, it would reverse the sequencing of such an intervention to come after the high intensity intervention, which would be novel. Qualitative research investigating OCD participants' views on low intensity interventions for OCD found that cCBT with telephone support was viewed by some as an acceptable compromise (Knopp-Hoffer, Knowles, Bower, Lovell, & Bee, 2016). Thus, investigating such a method for follow-up may be a promising avenue.

An alternative to these more technological approaches could be to extend the 'responsive regulation' model to follow-up (Stiles, Barkham, Connell, & Mellor-Clark, 2008). This model views patients as active decision makers in their care as opposed to recipients to services. Treatment duration and its end are determined in collaboration when the patient has improved to a 'good enough level' (Barkham et al., 2006). There is evidence to support the cost efficiency and effectiveness of this model (Stiles, Barkham, & Wheeler, 2015). Adopting this model to be used as an option for follow-up would allow service users to schedule follow-up appointments to see their therapist when required. The use of patient

led appointment scheduling has been successful when trialled in pilot NHS sites and a mental health care system within Australia (Carey, 2011; Carey, Tai, & Stiles, 2013). The fear that patients would access services indefinitely was not realised.

Overall, participants described a range of factors that they perceived as relevant to their preference of format. Underlying these was the premise that patients should be able to express their preference and that intensive CBT is a desired outpatient care option. Patients' expectancy of a preferred treatment is well documented as non-specific factor associated with treatment outcome (Arnkoff, Glass, Shapiro, & Norcross, 2002). Taken together the results of this study suggest that patient preference should be given consideration in clinical settings. However, how widely intensive formats of CBT are available is currently unknown and requires investigation.

Clinical Implications

Three key clinical implications can be derived from this study. The first pertains to ensuring time is spent early on in therapy to explore with the patient their view of their past therapy and to identify with them if there is utility on building on what they have previously learnt. Addressing individuals concerns and worries about therapy and treatment format before commencing treatment may also be of use.

Secondly, participants in this study perceived intensive CBT sessions to serve an important function. It may be the case that what is required is not necessarily a course of intensive treatment, but some extended format sessions with the capacity to make the space for what is therapeutically required. Participants view in-session therapist assisted ERP as an extremely important component of therapy, which is facilitated by longer sessions. Others described additional time being required for formulation and developing a shared understanding of the problem. Providing intensive sessions has implications for services in terms of provision but may be of benefit for participants who have already experienced multiple episodes of standard hourly CBT.

The third clinical implication pertains to the provision of follow-up sessions following therapy completion. The implication is that follow-up sessions may provide the judicious use of 'approach-supporting behaviours' (Salkovskis & Millar, 2016) helping patients to commit and engage in therapy knowing that follow-up is available if needed.

Limitations and Future Directions for Research

It is important that the findings from this study are considered within the context of their limitations. The recruitment strategy employed snowballing techniques, thus a random sample of participants with OCD was not recruited. Priority was given to recruiting participants who had multiple experiences of unsuccessful CBT. Nonetheless, appropriate measures were taken to ensure a clinical population with a confirmed diagnosis of OCD were recruited. The participants on average reported a relatively high degree of self-efficacy relating to their perceived capacity to overcome their OCD. Having confidence in oneself and in treatment are critical factors underlying positive change (Bandura, 1986). It is possible that this factor may have influenced participants' views. Thus, different views of intensive CBT may be held by those who have experienced multiple treatment failures but feel less confident in their ability to change. A different recruitment strategy would be required to investigate this. Ethnic minorities are also underrepresented in this study, this is a limitation that falls under a wider issues within the field of OCD research (Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012; Williams, Proetto, Casiano, & Franklin, 2012).

Conclusion

The findings of this study provide support for the NICE stepped care recommendation (2005, 2017), by indicating that intensive CBT for OCD is generally an acceptable treatment for individuals with OCD who have experienced multiple CBT failures. Participants reported that an intensive format may accommodate aspects of therapy that were poorly carried out or absent from weekly CBT that are perceived as important for successful CBT (e.g. in-session ERP). At the same time, reservations about the potential speed of intensive CBT make it overwhelming and susceptible to relapse, and the crucial need for follow-up in this context were also expressed. As should be central to all therapy, individual preference plays an important role and as with all treatments, an intensive format will not be well suited to all who have experienced previous CBT failure.

Appendix 1

Table 2.

Overarching themes, subthemes and headings

Overarching theme	Sub-themes	Headings within sub-themes
1. Continuity and Momentum	1.1 Therapeutic flow and engagement 1.2: "The therapy that gave me wings": In-session ERP 1.3: Big, Fast, Gains. 1.4: Clearing the decks for success	
2. Hmm, yes, But… reservations about intensive CBT	2.1: Too intense 2.2: Can I trust you? 2.3: Slap bang, crash and burn	Relevant to others Relevant to self Emotionally taxing Comorbidity CBT Content
3. The Fortune is in the follow-up		• Appropriate follow-up • Booster Sessions • Technology as follow-up • Flexibility and responsiveness to need • Allied health professionals • Disparity between mental and physical health services
4. Understanding Individual preference	4.1: Failing made me ready 4.2: Patient choice, circumstance and severity 4.3: The best of both worlds	

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CHAPTER 8: STUDY 4

Therapists' Perspectives and Utilisation of Intensive Cognitive Behavioural Therapy

Chapter Rationale

Study 3 identified that individuals with OCD perceived there could be substantial benefits to using alternative (intensive) formats for the delivery of CBT. These benefits included gaining momentum and continuity of treatment and the utilisation of an intensive format for in-session ERP. However, potential obstacles to engagement in intensive treatment were also raised, centring on the possibility that intensive CBT may require too much, too soon and that gains made quickly may be susceptible to relapse. While these reasons were identified from the perspective of the service user, the perspective of the therapist on this format of CBT is yet to be investigated. Alongside the views of service users, therapists' perspectives are critical to intervention uptake. Study 4 therefore employs a mixed methods approach to investigate therapists' views and utilisation of intensive CBT. This study not only focuses on intensive CBT for OCD but adopts a broader framework to examine the populations for whom therapists perceive intensive treatment is best suited.

This declaration concerns the article entitled:									
Therapists' Perspectives and Utilisation of Intensive Cognitive Behavioural Therapy.									
Publication status (tick one)									
Draft manuscript	x	**Submitted**		**In review**		**Accepted**		**Published**	
Publication details (reference)	Millar, J.F.A., Halligan, S.L., Gregory, J. & Salkovskis, P.M.								
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Candidate's contribution to the paper (provide details, and also indicate as a percentage)	Josie Millar made considerable contributions to the conception of the study (80%), as well as the methodological design (80%). The research process, including the acquisition of and analysis of data was predominantly conducted by Josie (90%). Josie also primarily executed the presentation of the study and associated data in journal format (90%) and presented associated content at national and international academic conferences.								
Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.								
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Therapists' Perspectives and Utilisation of Intensive Cognitive Behavioural Therapy

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Abstract

Objectives: Cognitive Behaviour Therapy (CBT) is an efficacious treatment for anxiety and anxiety related disorders, which is typically delivered in a weekly format over 6-12 sessions. Intensive CBT consisting of longer sessions has been developed as a treatment option which may be particularly useful for patients who struggle to engage with or have not benefitted from standard format CBT. The aim of this study is to examine National Health Service (NHS) therapists' views on, and use of, intensive CBT.

Design: Cross-sectional mixed methods design.

Methods: NHS psychological therapists (*N*=132) were recruited from professional development workshops. Participants completed a questionnaire examining their attitudes towards and experience of intensive versus standard format CBT, including factors informing choice of therapy format, their perception of therapy content, as well as benefits and disadvantages/ barriers to using intensive CBT. Descriptive statistics and qualitative content analysis were used to examine the resultant data.

Results: Therapists perceived intensive CBT to be equally or more effective than standard CBT. However, only 6% of therapists had experience of delivering it, although 93% of therapists expressed willingness to provide it. A total of 11 main categories were identified from the content analysis. Therapists identified benefits of intensive CBT in terms of therapeutic process (especially increased ability to use exposure related techniques), engagement and momentum, with consequent increased therapist satisfaction. Despite therapist willingness the main perceived barriers were resource and service related, along with perceived emotional and practical barriers.

Conclusion: For intensive CBT to be considered as a possible treatment format, consultation with key stakeholders supported by guidelines incorporating the evidence-base would be required.

Practitioner Points:

- Therapists' perceived that longer therapy sessions would be beneficial for conducting more therapist assisted exposure-based sessions and predicted that this would have benefits on treatment outcome.
- As most ERP efficacy studies utilise longer therapy sessions (commonly 90-minute sessions), it is important that therapists are given flexibility to lengthen sessions to accommodate ERP as needed.
- Service level obstacles will need to be addressed before intensive CBT will be considered an outpatient treatment format option.

Key words: Therapists perceptions, Cognitive Behavioural Therapy, CBT, Treatment Preferences, Intensive CBT, iCBT, Time-Intensive.

Introduction

Cognitive Behavioural Therapy (CBT) is an efficacious treatment for anxiety and anxiety related disorders (Baardseth et al., 2013; Hans & Hiller, 2013; Öst & Ollendick, 2017). CBT is traditionally delivered in weekly sessions of 50-60 minutes (Beck & Beck, 1995). However, in recent years there has been increasing interest in more flexible delivery formats, with time intensive CBT being developed for some conditions. Most notably, time intensive CBT has been applied to specific phobias, where treatment has successfully been delivered in a long, single session format (Ollendick et al., 2009; Öst, 1989). Time intensive interventions have also been developed for Obsessive Compulsive Disorder (OCD) (Challacombe et al., 2017; Storch et al., 2008), Post-Traumatic Stress Disorder (PTSD) (Ehlers et al., 2010; Ehlers et al., 2014) and Panic Disorder (Whitton & Pincus, 2012). In these cases, a standard course of therapy is condensed into approximately one to three weeks, with each session being two to four hours in length.

Such developments have potential benefits for therapy delivery, as well as for patient accessibility. For example, CBT for OCD (and several other anxiety disorders) typically include Exposure and Response Prevention (ERP) (Olatunji et al., 2013; Öst et al., 2015) as one of the key active components of therapy (McKay et al., 2015). However, ERP is reported by both therapists (Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Hipol & Deacon, 2012) and service users (Millar, Halligan, Gregory, & Salkovskis, in prep.) to be underutilised in therapy. Although many factors may contribute to the underutilisation of ERP, including therapists' negative beliefs about ERP being too difficult to tolerate (Deacon et al., 2013; Ong et al., 2016), it is suggested that underutilisation may also be a consequence of the time restrictions imposed by the design of the 50-60 minute therapy session (Jacobson, Newman, & Goldfried, 2016). To deal with this, therapists may offer more intensive sessions, where several hours of treatment take place on the same day. However, this is typically done on an ad hoc basis and it is unclear how often and widely this approach is utilised in clinical practice.

Therapists' beliefs about the efficacy of the treatment and their attitudes towards the treatment they provide are important to intervention uptake and delivery (Ong et al., 2016; Wiborg et al., 2012). Therapists' beliefs and attitudes can influence a number of factors such as treatment choice, adherence, expectancy, motivation and therapeutic alliance, which can all have an impact on treatment outcome (Ackerman & Hilsenroth, 2003; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Keeley, Geffken, Ricketts, McNamara, & Storch, 2011; Vogel, Hansen, Stiles, & Gotestam, 2006). Therapists' beliefs about the therapy they provide can also influence patients' expectations about therapy (Joyce & Piper, 1998). Given

growing evidence that intensive CBT is effective and acceptable to service users (Bevan, Oldfield, & Salkovskis, 2010; Challacombe et al., 2017; Jónsson et al., 2015), and is recommended by the National Institute for Health and Care Excellence (NICE) in some circumstances (NICE, 2005), it is essential to examine the acceptability of intensive CBT to the *therapists* who would be providing such treatment.

In the current study, we used a mixed methods approach to examine therapists' views of using intensive CBT in clinical practice for anxiety and anxiety related disorders. We administered questionnaires to a sample of psychological therapists and conducted quantitative analyses of ratings of items examining attitudes to intensive CBT, as well as content analysis of open text responses. We specifically sought to examine the following research questions:

1. For which disorders do therapists perceive an intensive format of CBT to be relevant and beneficial?
2. What factors guide and influence therapist choice of therapy format and its delivery?
3. Do therapists perceive there to be a difference in the content of 'standard' and 'intensive' CBT?
4. What do therapists perceive as (a) advantages of and (b) disadvantages or barriers to the implementation of intensive CBT?

Method

Participants

A total of 132 psychological therapists participated in this study. Participants were eligible to take part if they were 18 years and above and were working in a National Health Service (NHS) setting as a qualified psychological therapist. Participants were recruited from attendees of full-day continuing professional development (CPD) workshops on CBT for OCD. The content of the workshop covered the theoretical underpinnings of CBT for OCD (Salkovskis, 1985, 1999) and practical applications for treatment, but did not include consideration of intensive CBT for OCD. In total, 354 pencil-and-paper surveys were distributed across seven different workshops over an 18-month period. A total of 158 surveys were returned completed, with a response rate of approximately 44%, which is comparable to other surveys of psychological therapists (Becker et al., 2004). Subsequently, 26 questionnaires from student attendees were removed as the study focused on qualified psychological therapists with clinical experience, leaving 132 participants in the final sample.

Measure

A questionnaire was developed specifically for this study and presented to participants in paper format. The questions explored therapists' attitudes towards and utilisation of intensive CBT for anxiety and anxiety related disorders. The survey consisted of two parts; 1) a series of demographic questions including age, gender, profession, number of years in practice, therapeutic orientation and disorders treated; and 2) a series of 11 questions examining views on intensive CBT. A combination of forced choice and open text responses was used.

Following provision of background information, therapists were asked how they would define standard and intensive treatment formats in terms of the number of sessions per month, duration of each session and the time period over which it would be delivered. To determine the factors that lead therapists to decide what format to use, they were asked to describe in their own words what would guide selection and content of each of the treatment formats. Therapists were then provided with the following definitions for standard and intensive CBT;

> **Standard.** *Therapy is delivered at weekly intervals for 12-18 weeks. Sessions are 50-60 minutes in length. Home and/ or field visits can be included and may require a longer session time. Between one and three booster sessions can be offered once formal therapy sessions have been completed.*
>
> **Intensive.** *Therapy of 12-18 hours is delivered over a three-week period. Typically, two sessions will be delivered in the first week of three to six hours and two or three sessions in the following two weeks of six to eight hours. The therapy will involve home and or field visits. Between one and three booster sessions can be offered once formal therapy sessions have been completed.*

These definitions were drawing from those in the existing literature (Beck & Beck, 1995; Jónsson et al., 2015). With reference to these definitions, the remaining open text questions asked participants to consider the potential facilitators, advantages, barriers and disadvantages to the different formats (e.g., 'What do you envisage the disadvantages of providing therapy in an intensive format as opposed to standard weekly sessions might be in general and for yourself as a therapist?'; 'How do you think intensive CBT would impact homework tasks?').

Procedure

The study protocol was reviewed and given ethical approval by the University of Bath Psychology Research Ethics Committee (Ref: 12-069). Therapists who attended one of seven OCD focused CPD workshops were invited to take part in the study by the first author, either on their arrival at the workshop or during an interval during the day. Paper copies of the questionnaire and a reply-paid envelope were provided to the attendees. Participants completed the questionnaire either during the lunch break, at the end of the day or took it away with them and returned it by post.

Data Analytic Strategy

Descriptive statistics were used to summarise demographic information and responses to questions that were quantitative in format. Qualitative content analysis (QCA) was utilised to analyse text responses to open ended questions. QCA provides a systematic method for making inferences from written data in order to describe, understand and quantify specific phenomena for a particular purpose (Hsieh & Shannon, 2005; Vaismoradi, Turunen, & Bondas, 2013). It is widely used in health research as a flexible method for synthesising large amounts of text into meaningful categories, and is recommended for exploratory work in areas that are not well understood (Elo & Kyngäs, 2008). Inductive QCA was employed as there are no previous studies exploring therapists' views on intensive CBT (Elo & Kyngäs, 2008). The three-stage process of inductive QCA was followed (Elo & Kyngäs, 2008). First, *preparation* involved all text from each respondent's questionnaire being accumulated verbatim under the corresponding research question within one document. Following this, immersion in the data commenced via the reading of text responses to gain a sense of the dataset. The 'unit analysis' selected was the entire section of text that had been merged together specific to each research question. The data were analysed at the manifest content level only (i.e. the data were seen as representing a valid report of the participant's reality, with the meaning being explicit in the data). Second, the *organising* stage began with 'open coding' in which the data is read and annotated with notes and headings in order to describe all aspects of the content (Elo & Kyngäs, 2008). Following this the notes and headings were accumulated onto a separate coding sheet and the codes were then generated directly from the data. The *codes* (along with their frequency) were sorted into *categories* based on how they were related, organising the codes into meaningful clusters. A tree diagram was developed to help organise categories into a hierarchical structure using higher order headings in order to reduce the number of categories. In the final stage, *reporting*, the process of abstraction was followed in which a general description of the research topic was generated via the organisation of categories to provide a definition. Finally, a conceptual

map was developed with exemplars for each code and category identified from the data (Elo & Kyngäs, 2008).

The analysis was conducted by the first author, a clinical psychologist experienced in CBT for OCD and anxiety disorders. A second psychologist with a research background reviewed the data file and followed the same 'open coding' method as described above for 25% of the data for each research question. The codes and categories that had been generated by the second coder were compared and contrasted with those of the first author. There was a high level of agreement between the codes and categories generated by both researchers and four minor changes were made to the names of codes and categories as a result of this process.

Results

Participants

Therapists (N = 132) ranged in age from 23 to 67, with a mean age of 41 years (SD = 10.1). Women comprised 71% of the sample. Years in practice (post-qualification) ranged from one to 39 years (M = 7 years, SD = 7.8). The sample included clinical psychologists (27%) and CBT therapists from an allied health background (62%) [including mental health nursing (21%); social work (6%); occupational therapy (2%), Improving Access to Psychological Therapies programme (IAPT) (33%)], counselling psychologists (7%) and psychiatrists (4%).

The majority of respondents (87%) reported CBT as their predominant therapeutic orientation utilised in clinical practice. Although therapists were recruited via an OCD focused CPD workshop, as can be seen from Table 1 (which shows the number of patients treated per disorder in the prior 12 months), participants had experience with treating each of the more common anxiety/anxiety related disorders.

Table 1.

Therapist-reported number of patients treated per disorder in previous 12-month period

Patients Treated	Obsessive Compulsive Disorder	Generalised Anxiety Disorder	Post-Traumatic Stress Disorder	Panic Disorder	Social Phobia	Health Anxiety	Specific Phobia
	N (%)	*N (%)*	*N (%)*	*N (%)*	*N (%)*	*N (%)*	*N (%)*
0	12 (9.1)	17 (12.9)	26 (19.7)	14 (10.6)	18 (13.6)	39 (29.5)	56 (42.4)
1-5	67 (50.8)	54 (40.9)	69 (52.3)	64 (48.5)	65 (49.2)	67 (50.8)	56 (42.4)
6-10	28 (21.2)	20 (15.2)	18 (13.6)	22 (16.7)	30 (22.7)	17 (12.9)	9 (6.8)

11-15	12 (9.1)	12 (9.1)	7 (5.3)	10 (7.6)	8 (6.1)	3 (2.3)	1 (.8)
16-20	2 (1.5)	6 (4.5)	1 (.8)	4 (3)	3 (2.3)	1 (.8)	3 (2.3)
Over 20	7 (5.3)	17 (12.9)	5 (3.8)	9 (6.8)	3 (2.3)	2 (1.5)	1 (.8)

Quantitative outcomes

Therapist understanding of intensive versus standard CBT delivery formats

The majority of participants endorsed standard CBT as comprising four to six sessions a month (82%), delivered over three to four months (69%), as delivered within their clinical NHS setting. There was somewhat less consensus with respect to format of intensive CBT. Participants reported that they perceived an intensive format of CBT to comprise of four to eight (39%) or eight to twelve (42%) sessions per month, over a time period of between one to two months (44%).

Perceptions of Likely Benefit and Effectiveness of Intensive Format

After being provided with a standardised definition of 'standard' and 'intensive' CBT, participants were asked to rate which disorders they believed would be most likely to benefit from an intensive format of CBT. Over half of the participants identified OCD (84%), Panic Disorder (71%) and Specific Phobia (65%). The majority of participants (66%) indicated that they perceived an intensive format would be slightly more effective or more effective in comparison to standard weekly treatment. Only 6% of the sample believed that intensive treatment would not be as effective as standard treatment (Figure 1).

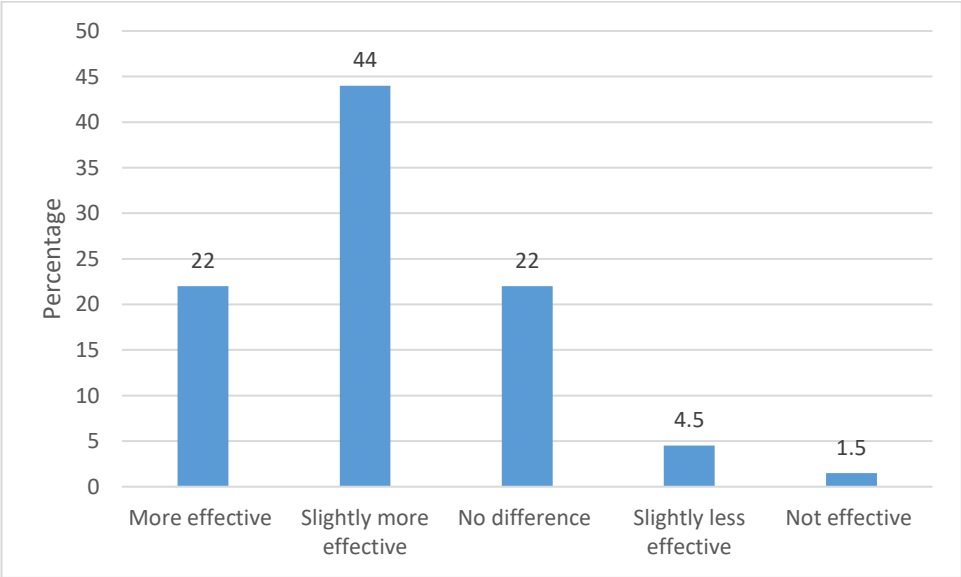


Figure 1. Bar chart showing therapists' perception of effectiveness of intensive CBT in comparison to standard CBT

Despite positive perceptions of intensive CBT, the vast majority of therapists (94%) reported that they do not offer an intensive format of CBT within their NHS service. However, 93% of these therapists indicated that they would be willing to consider providing CBT in an intensive format if it was possible to do so.

During the analysis we checked whether the reports of the 6% with prior experience of intensive CBT deviated from the rest of the sample. The perceptions of this subgroup was overall positive, but included some constraints to delivery, consistent with the wider sample.

Qualitative Content Analysis Outcomes

Content analysis identified 11 main categories (summarised with supporting quotes in Table 2). For each category, the proportion of the sample identifying the category (divided according to standard versus intensive formats where relevant) is reported, with the equivalent statistics for individual codes defining the category also being presented. See Appendix 1 for a visual representation of the main categories.

Factors Informing Therapist Choice of Therapy and Format of Delivery

The first set of qualitative data focused on text responses to questions regarding what factors would guide therapist's choice of therapy and its delivery format (i.e. intensive or weekly).

Two main categories were identified: the *'Scientist-Practitioner Approach'* and *'Idiosyncratic Considerations'***.** Both were consistently reported by therapists for *both* standard and intensive formats. A third main category *'Disorder severity and capacity to engage'* was identified specific to intensive CBT.

The first main category *'Scientist-Practitioner Approach'* (standard 73%, intensive 56%) was abstracted from codes which drew on aspects relevant to best practice. Therapists reported that their therapy would be guided by the evidence-base for the disorder they were treating, underpinned by CBT theory, with information being derived from sources including NICE guidelines, the use of protocols, and research papers (standard 64.2%, intensive 51.2%). The importance of using outcome measures (standard 2.3%, intensive 1.5%) and supervision (standard 6.1%, intensive 3%) were also reported, but less frequently.

The second main category *'Idiosyncratic Considerations'* (standard 96%, intensive 62%) was abstracted from codes in which the use of a formulation (which was collaboratively developed with the patient) and the patient's goals, presentation and individual needs were identified as guiding therapy (standard 86.3%, intensive 56.5%). The therapists' experience of working with the presenting problem and the therapeutic

relationship (standard 9.2%, intensive 5.4%) also comprised this main category, although to a much smaller degree.

Specific to the intensive Format was the main category ***'****Disorder severity and capacity to engage'* (32%). Emphasis was given to an intensive format being chosen if the therapist perceived the patient's symptoms to be of significant severity and thus requiring a larger proportion of exposure-based work. The perception of how willing, motivated and able the patient is to engage and tolerate an intensive treatment and the practicalities of this for the individual were discussed. In addition to the main categories identified, 15% of therapists reported that they did not know what would guide intensive CBT.

Table 2.

Results of Qualitative Content Analysis: Main categories identified specific to each research question with exemplars from the data

	Main Category	**Participants quotes**
Factors informing therapist *choice* of therapy and *format* of delivery	**Scientist Practitioner Approach** Standard 73% Intensive 56%	**Participant 88 -** *"Theoretical models, evidence-based treatment & interventions"*. **Participant 106 -** *"Theory, research and training. Evidence-based".*
	Idiosyncratic Considerations Standard 96% Intensive 62%	**Participant 69 -** *"Hypotheses developed collaboratively with the patient, Formulation and their goals for therapeutic outcome".* **Participant 126 -** *"Collaboration and shared understanding always play a major part! Two people solving a difficulty together. It's very important for me to keep the human touch".*
	Disorder severity and capacity to engage (32% Specific to Intensive only)	**Participant 61 -** *"Practical consideration of resources, how quickly the patient could move in terms of tackling emotional challenges and how ready the patient is to endure discomfort and anxiety"*. **Participant 54 -** *"Patients' level of motivation, severity of problem, duration and ability to commit to therapy. If OCD would choose ERP as therapy focus".*

Therapist perception of *content* of intensive compared to standard CBT	**Increased Exposure** (63%)	**Participant 49 -** *"More time to spend with the patient helping them carry out behavioural experiments".* **Participant 45 -** *"Build on repeated exposures, reinforce learning in a meaningful way for the patient who can learn from a real, lived experience. Rather than a potentially abstract, 1-hour session".*
	Out of session engagement (65%)	**Participant 07 -** "*Homework tasks more likely to be completed as had opportunity to observe greater gains with therapist support, before being required to do them independently".* **Participant 47 -** *"More opportunity to discuss issues that have arisen in therapy and homework and therefore correct misunderstanding and situations where homework has not been fully completed".*
Perceived *benefits* of Intensive CBT	**Momentum and continuity of treatment leading to rapid change** (100%)	**Participant 56 -** "*Good for fitting in with work + avoids problems of between sessions forgetting + more rapid change is itself motivating".* **Participant 51 -** *"Keeps the focus clear. Rapid exposure and change. Enhanced motivation and morale associated with rapid response and early achievement".*
	Therapist Satisfaction (71%)	**Participant 55 -** *"Personally, therapist can keep patient engaged in treatment and may have more successful outcomes giving job satisfaction. Also, the intensive format would promote the therapeutic alliance with the patient".* **Participant 100 -** "*Therapist – quicker turnover of patients, shorter waiting list/time, more focused, less therapeutic drift".*
Perceived *disadvantages* and *barriers* to the	**Resource and service-related limitations** (100%)	**Participant 58 -** *"I am not 'supposed' to provide intensive treatment, but I do when required and appropriate (the barriers are management and I*

implementation of intensive CBT		*bypass them). Intensive treatment is usually mostly delivered outside clinic - in real life situation".* **Participant 22 -** *"Organisational constraints – demands to have assessments available, keep meeting targets etc. make it difficult to create space for something new. Managerially – I would need convincing that there is evidence this is as effective (or better) than standard".*
	Anticipated impact on therapist (58%)	**Participant 74 -** *"I wouldn't be able to see as many patients in a week which would result in me not meeting my service targets. It's also a very big commitment which could be quite draining".* **Participant 14 -** *"Would need detailed supervision prior to intensive session to ensure effectively planned and prepared for, as lots of variations in outcome are more likely than in weekly and monthly sessions".*
	Emotional & Practical Barriers (100%)	**Participant 70 -** *"Patient Might be frightened. See it as too much too soon".* **Participant 67 -** *"Some would relish it – want to get well quick. Others (perhaps more) might feel daunted /anxious. Practical issues may deter others and possibly if there is ambivalence about being in therapy it might affect willingness to enter intensive therapy."*
	Impact on therapy outcome (90%)	**Participant 44 -** *"I would worry that progress may cease once therapy ended as there is less chance to practice ERP independently".* **Participant 62 -** *"Less time for change between sessions, working on homework, sense of attributing change to therapy rather than patient themselves".*

Therapist Perception of Content of Standard and Intensive CBT

The second set of qualitative data comprised items focused on therapeutic content. The majority of participants (73%) perceived that the content of CBT would be the same for

standard and intensive treatment formats, but that the focus of an intensive format of CBT would be different. Two key perceived changes in focus were identified.

The first is captured by the main category *'Increased Exposure'* (63%). Therapists emphasised that an intensive format would create more time for *in vivo* behavioural experiments and ERP (51%). An increased focus on in-therapy session exposure was perceived to facilitate greater modelling of ERP led by the therapist and increased support (12%).

The second change in focus is represented by the main category *'Out of session engagement'* (65%). This captures the perceived change in how homework may be set, utilised and engaged with within an intensive format. It was perceived that it would be easier for homework to be implemented in an intensive format and that patients would be more likely to carry out their homework, and that greater revision of and feedback on homework from the therapist would occur (60%). A smaller percentage of therapists suggested that an intensive format may lend itself to greater opportunities for family member involvement in therapy (5%).

Perceived Benefits of Intensive CBT

Therapists were asked to consider if there were any potential benefits they could foresee regarding an intensive format of CBT. Two main categories were abstracted that represent advantages perceived by therapists regarding an intensive format. The first was '*Momentum and continuity of treatment leading to rapid change',* which was reported by 100% of participants. This encompassed the idea that an intensive format would facilitate opportunities for treatment to be more focused and for momentum to build, allowing patients to make more immediate gains (76%). It was suggested that it may be practically easier for some patients to schedule an intensive treatment and that carving out this specific block of time to focus on getting well could be beneficial (21%). Associated with the benefits of increased focus and faster gains was the perception that intensive CBT would lead to faster lowering of distress, less drift and avoidance, increased patient motivation and confidence and the engendering of hope (98%). Based on the aforementioned benefits, therapeutic rapport was expected to be positively affected, thus increasing trust in the therapist and therapy process, resulting in increased engagement and consolidation of therapeutic content (36%).

The second main category abstracted was *'Therapist Satisfaction'* (71%). This encompassed the possibility of an intensive format being rewarding for the therapist. This was due to the perceived opportunity to focus on one patient in more detail with greater

scope to assess, understand and provide a more in-depth, thorough treatment. It was suggested that the therapist would be more engaged with the therapy as they would have sufficient time to employ in vivo exposure work, enabling them to observe subtleties in safety behaviours, provide immediate feedback, ensuring the patient is kept on track and that progress is made and maintained (47%). Some therapists perceived an intensive format would be beneficial for the service, suggesting that it would be both cost effective and time efficient. Specifically, it was suggested that the service may experience less cancellations or missed appointments and potentially shorter waiting lists; and that intensive therapy may lead to less burn out and therapist fatigue (24%).

Perceived Disadvantages and Barriers to the Implementation of Intensive CBT

Therapists were asked to consider what barriers would deter them from offering intensive treatment to patients. Four main categories were identified with the predominant being *'Resource and service-related limitations'* (100%). A key barrier to implementation was perceived to be the constraints of the service itself. Participants noted that as intensive CBT is not a part of routine clinical practice, implementing it would involve a process of convincing managers of its benefits. Following this it was suggested that several logistical and time management difficulties may arise, with therapists finding it difficult to find the time to arrange intensive CBT whilst also balancing weekly patients (41%). The occurrence of drop-out or sickness on behalf of the patient or therapist, and the impact that this could have on service delivery and productivity was also noted as an important consideration (13%). The perceived requirement of more frequent supervision that would need to be carefully planned and may be difficult to implement due to the intensity of the work and service limitations was reported by the majority of participants (94%).

Therapists expressed their concern with regards to their professional and personal capacity to carry out intensive CBT. This was captured in the second main category '*Anticipated impact on therapist'* which was reported by 58% of therapists**.** Some therapists were concerned that they may find intensive CBT draining or exhausting or find it too personally challenging if they were not used to providing CBT in that format (21%). The idea of having a patient that is 'challenging' to work with and not being able to take a 'break' from them, with the consequent possibility of burn out, was raised (8%). Concern was expressed by some therapists that they lacked the experience and expertise to provide intensive CBT, coupled with the belief that a more specialist supervisor with experience in this format would be required (29%).

The third main category is *'Emotional & Practical Barriers'* (100%) which was endorsed by all therapists. Therapists reported that they thought that some patients would perceive the idea of intensive treatment as too scary; too intense or demanding; anxiety provoking; overwhelming or daunting (53%). It was suggested that patients may be concerned with how quickly the treatment takes place and may doubt that a problem they have had for so long could be helped so quickly, or concerns about the therapy failing from the outset (21%). Therapists also perceived that patients may view the prospect of intensive CBT as difficult to commit to due to the impact it may have on their lifestyle, family and significant others with regards to practical arrangements (53%) (I.e. time off work, childcare arrangements).

The fourth main category is *'Impact on therapy outcome'* (91%). Therapists expressed concern that due to the shortened time period of intensive CBT, patients may not have enough time to integrate the changes into their daily life and encounter events that may be triggering and to recover from setbacks whilst still in therapy. Concern was expressed regarding gains that are made being maintained leading to questions regarding relapse and long-term effectiveness (41%). Therapists expressed concern that patients may not be given enough homework or time to practice independently, which may impact negatively on consolidation of learning (50%).

Discussion

Our examination of therapists' use and views on intensive CBT for anxiety disorders found that the majority of therapists were enthusiastic about the possibility of implementing intensive CBT, with three quarters of therapists perceiving it to be potentially more effective than standard CBT. Key advantages of intensive CBT included the potential for more time to incorporate exposure-based work into therapy sessions, along with a likely increase in momentum resulting in faster gains, with resultant benefits to the patient and therapist. Therapists' also perceived that intensive CBT was likely to promote better engagement with homework and that increased therapist satisfaction would be a by-product of this approach. Despite 93% of therapists' indicating they would be willing to deliver intensive CBT, only 6% of therapists had previous experience of this. Moreover, all therapists reported obstacles to implementing intensive CBT, with specific key barriers being related to constraints of the service and logistical factors. The perceived emotional burden and practical difficulties for both the therapist, patient, and potential adverse consequences for treatment outcome were also identified as major concerns.

Therapists perceived intensive CBT to be potentially most helpful to patients who are deemed 'severe' and would benefit from an increase in the exposure related element of

CBT. Although the content of standard and intensive formats was perceived *not* to differ overall, the *focus* of intensive CBT was perceived to include more dedicated time to in-session therapist accompanied ERP, or *in vivo* behavioural experiments. It is promising that therapists in this study clearly hold positive views about the value and utility of ERP, as therapist assisted ERP has been linked to superior treatment outcome (Abramowitz, 1996; Tolin et al., 2007). The current findings suggest that therapists perceive longer sessions to be optimal for carrying out exposure-based work, and that adherence to standard 50-60 minute weekly sessions may act as a barrier to adequate use of exposure in clinical practice. Research has shown that ERP conducted in a more flexible way, for example in the patient's home, can be effective (Rowa et al., 2007). The current findings suggest that finding ways to deliver therapy in longer blocks may be particularly crucial for exposure-based components. Alternatively, as suggested by Insel (2009), outcomes in therapy may be improved by developing more personalised care. An important part of this may be equipping therapists to conduct ERP/ BE in a way that is achievable in 50-60 minutes, including building their confidence in delivering shorter blocks of ERP for more complex cases.

Over half of therapists perceived intensive CBT would positively impact on homework, with therapists predicting greater out of session engagement, homework completion and potential family involvement. It is well established that engagement with homework positively affects treatment outcome (Kazantzis, Whittington, & Dattilio, 2010), particularly when patients engage early in treatment and undertake exposure based components (Simpson et al., 2011). Thompson-Hollands et al. (2015) found that involvement of family members via an adjunctive intervention produced a more rapid treatment response in comparison to individual CBT only. As such, therapists in the current study identified engagement related benefits of intensive CBT that have potential benefits, in turn, for treatment outcomes.

Therapists emphasised the benefit of intensive CBT leading to increased momentum and continuity resulting in treatment gains being made more quickly. Therapists perceived that faster gains were key to more rapid lowering of distress and building of patients' confidence, which was perceived to positively impact in a stronger therapeutic alliance being built early in therapy. This view is consistent with research, which has shown that early therapeutic gains can strengthen therapeutic alliance (Waller & Turner, 2016) and that therapeutic alliance is unlikely to change from the perspective of the patient as therapy progresses. Therapists perceived that such benefits were likely to impact positively on their own job satisfaction. With respect to standard sessions, therapists perceived an important

aspect that may be missing is the time and continuity to pick up on subtleties in safety behaviours and to give immediate feedback which would be afforded by longer sessions.

While therapists identified multiple potential benefits of intensive CBT, in practice only 6% were utilising this approach. Therapists perceived a range of significant barriers preventing them from implementing intensive CBT. A key perceived barrier was service constraints, where therapists highlighted that given the multiple competing demands on services, intensive CBT may not be logistically compatible with present service processes. Compelling evidence and guidelines would be needed to justify why an intensive approach should be included as a treatment format option, given such constraints. At present the NICE (2005) guidelines only recommend an intensive format for patients with severe OCD who have not responded to $\geq$ 2 courses of CBT and pharmacological augmentation. Evidence is still emerging to support the use of intensive CBT with different populations (e.g. Challacombe et al., 2017; Ehlers et al., 2014), and the current evidence-base certainly would not justify a wholesale shift in service provision/patient flow based on current knowledge of efficacy of an intensive format.

The other large barrier perceived by therapists was the idea that it would be too emotionally challenging and practically difficult for patients to organise and engage in intensive CBT. This is both consistent and in contrast with previous research where patients were divided on this issue. Some participants perceived intensive CBT to be potentially overwhelming for others, but not themselves, while others perceived this to be the case for themselves (Millar, Salkovskis, Gregory, & Halligan, in prep.). More research is needed to understand patient attitudes in this regard. Moreover, although over half of therapists perceived that homework engagement would be highly facilitated by intensive CBT, half of participants were concerned that it may not be possible to set enough homework between sessions, and that time to consolidate learning may not be sufficient. These serious concerns about potential adverse consequences of an intensive format for therapeutic efficacy are at odds with the limited available evidence and NICE guidelines on this point and are essential to overcome if intensive format CBT is to be delivered more widely.

Limitations and Future Research Directions

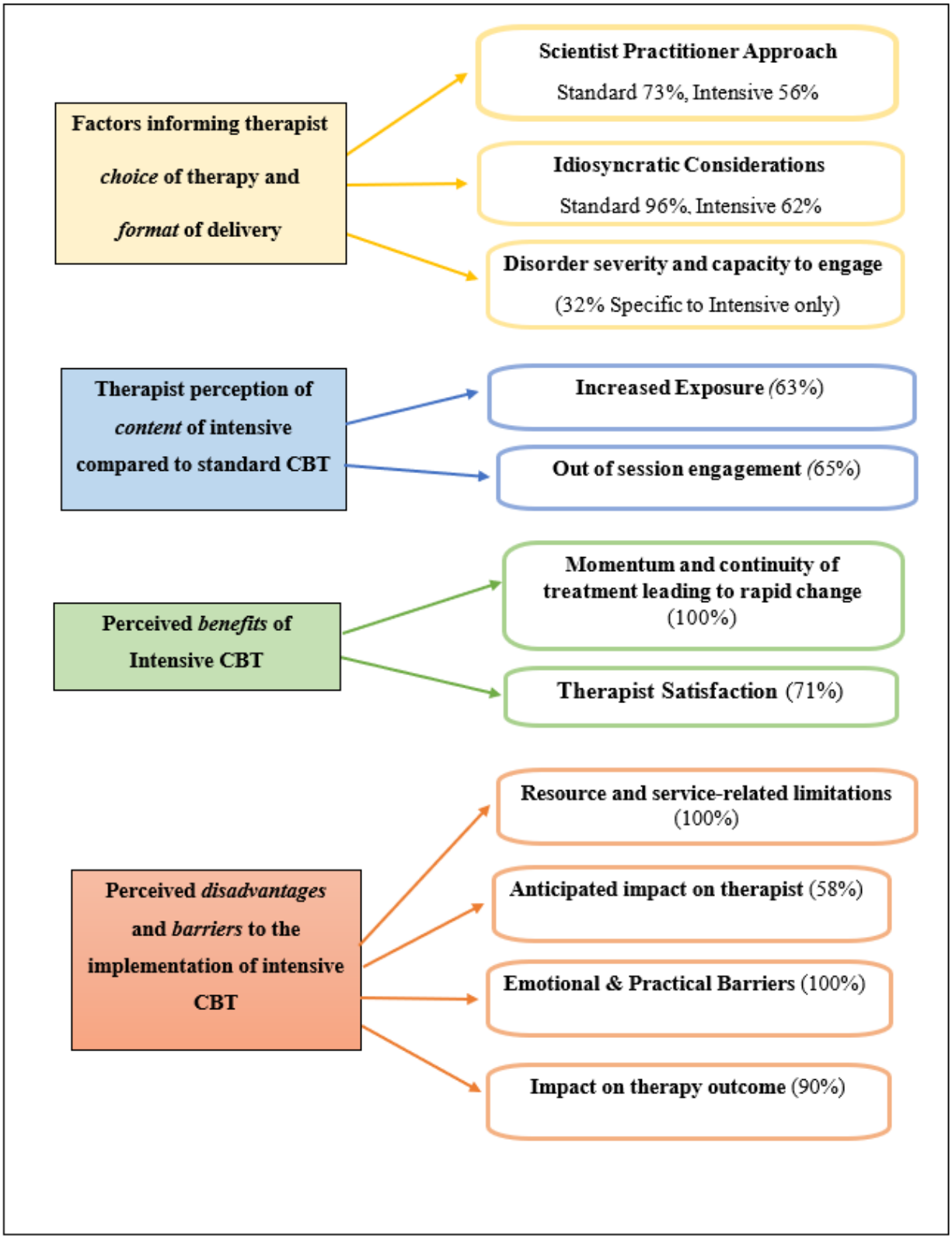
An important limitation of this study is the generalisability of the results. Although purposive, it was nonetheless a sample of convenience which comprised individuals with an interest in CBT for OCD. Consequently, it is possible that the findings are not reflective of those held by the wider population of CBT therapists working in the NHS.

In addition, the perspectives captured in this study were isolated to those of therapists. Considering one of the largest perceived barriers to intensive treatment is '*Resource and service-related limitations',* it would be important for future research to consult with and gain the perspectives of service managers. Future research designed to examine therapists' experiences before, during and after a course of intensive CBT would be useful in gaining a more in-depth picture, captured in real time.

Conclusion

The majority of CBT therapists are not conducting intensive CBT, with potential reasons for this including practical constraints and concerns about potential negative impacts on outcome. However, at the same time, the majority of therapists perceived there to be multiple benefits to conducting intensive CBT, including improved and quicker outcomes, with these benefits also endorsed by those with experience of delivering CBT in this format. Given the increased research attention on investigating intensive CBT formats for the treatment of various anxiety disorders, and the recommendation of such treatment approaches in clinical guidelines (e.g. NICE, 2005, 2013), the present research suggests some of the factors that need to be considered to enable therapists to adopt these advancements into their clinical practice.

Appendix 1: Figure depicting the main categories identified in response to each research question.



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CHAPTER 9: STUDY 5

Preference for Delivery Format of Cognitive Behavioural Therapy for Obsessive Compulsive Disorder

Chapter Rationale

Study 5 builds on the findings of Study 2, 3 and 4 by providing a quantitative investigation of the perceptions of intensive CBT amongst a large sample (N = 235) of OCD sufferers. The questions of the 'Treatment Preference Questionnaire' (TPQ) used in Study 5 were derived from the themes that were identified in the previous studies. Qualitative research is particularly useful for the generation of data-based hypothesis and research questions. This is because qualitative methods do not require you to specify in advance which factors from your data will be most relevant (Yardley and Bishop, 2017). Thus, the qualitative findings that have resulted from the three previous studies have been particularly useful as a means of systematically generating the research questions that are addressed in this study, and have highlighted key therapeutic (e.g., potential for better momentum, concerns about being overwhelmed), and practical (e.g., easier to make space/dedicate a block of time to intervention) considerations in defining attitudes to intense format CBT. This study uses quantitative methods to investigate the preferences of individuals with OCD from both a practical and therapeutic perspective.

This declaration concerns the article entitled:			
Preference for Delivery Format of Cognitive Behavioural Therapy for Obsessive Compulsive Disorder.			
Publication status (tick one)			
Draft manuscript [x]	**Submitted** [ ]	**In review** [ ]	**Accepted** [ ] **Published** [ ]
Publication details (reference)	Millar, J.F.A., Salkovskis, P.M., Gregory, J. & Halligan, S. L.		
Copyright status (tick the appropriate statement)			
I hold the copyright for this material [x]		Copyright is retained by the publisher, but I have been given permission to replicate the material here [ ]	
Candidate's contribution to the paper (provide details, and indicate as a percentage)	Josie Millar made considerable contributions to the conception of the study (80%), as well as the methodological design (80%). The research process, including the acquisition of and analysis of data was predominantly conducted by Josie (90%). Josie also primarily executed the presentation of the study and associated data in journal format (80%).		
Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.		
Signed		**Date**	27.09.2019

Preference for Delivery Format of Cognitive Behavioural Therapy for Obsessive Compulsive Disorder

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Abstract

Objective: We examined patient preferences for the format of delivery of Cognitive Behavioural Therapy (CBT) for Obsessive Compulsive Disorder (OCD) with a specific focus on weekly or intensive format.

Method: We recruited 235 adults who identified OCD as their main problem and met DSM-5 diagnostic screening criteria for OCD. Participants completed an online questionnaire that examined treatment preference from both a practical and therapeutic perspective. Analyses examined overall preferences; and tested prediction of treatment preference by demographic, symptom severity, functional impairment, treatment history and desire-to-change variables.

Results: Overall, participants endorsed weekly format versus intensive CBT to be preferable from a practical perspective, and there was no preference for weekly or intensive CBT with regards to perceived therapeutic benefits. Being older, more educated and currently in employment was associated with a practical preference for weekly format, while having greater functional impairment and problem recognition was associated with stronger preference for an intensive format from a practical perspective. Participants with higher general anxiety ratings preferred an intensive format from a therapeutic perspective. Previous experience of CBT was also an important determinant of delivery format preferences; participants who had previously experienced intensive CBT or who had undertaken a greater number of courses of weekly CBT, or who expressed a greater desire-to-change expressed a preference for intensive treatment.

Conclusions: Intensive format CBT is more likely to be acceptable to a certain group of OCD suffers, primarily those who have previously undertaken more than one trial of weekly CBT, those who have a strong desire-to-change and those who have already experienced intensive CBT. This study provides support for the NICE guidance recommendations for the provision of intensive CBT at an advanced stepped care level.

Practitioner Points:

- Participants with relatively severe OCD and high levels of impairment, reported on their preferences for the delivery format of CBT (i.e. weekly or intensive formats).
- In this sample many participants had previously received weekly CBT, and this aligned with their practical preferences for treatment in weekly format.
- Factors that may be clinically important when discussing preference for treatment format with a patient may be their employment status, previous treatment history, recognition of OCD as a problem and possibly their desire-to-change.

- Participants who had undertaken a higher frequency of previous CBT along with those who had experience of intensive CBT expressed a preference for intensive CBT. This finding supports NICE guidance that an intensive version of treatment should be offered to people who have experienced $\geq$ 2 previous courses of CBT.
- Future research should investigate whether assessing preference and incorporating this clinically has an impact on treatment engagement or outcome.

Key words: Obsessive Compulsive Disorder, OCD, Cognitive Behavioural Therapy, CBT, Treatment Preferences, Intensive CBT, Time-Intensive.

Introduction

Obsessive Compulsive Disorder (OCD) is a relatively common disorder, with life-time prevalence estimates of between 1 and 3% (Kessler et al., 2005; Ruscio et al., 2010; Subramaniam et al., 2012). Onset generally occurs in late adolescence/ early adulthood and there is often a substantial gap between the onset of significant life interfering symptoms and help seeking (Fineberg et al., 2019). This delay can lead those affected to develop high levels of severity, impairment and disability (Torres et al., 2006).

Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) is the first-line psychosocial treatment for OCD. The largest meta-analysis to date has reported that up to 68% of participants achieve clinically significant change following a course of CBT for OCD, comparatively higher than for antidepressant medication (33%) and placebo (27%) (Öst et al., 2015). Nonetheless, this still means approximately a third of OCD sufferers do not significantly benefit. One obstacle to treatment efficacy for individuals with OCD is willingness to engage with CBT. While studies examining OCD patients' preferences for evidence-based treatments for OCD have shown that patients prefer ERP with or without medication over medication alone (Patel, Galfavy, Kimeldorf, Dixon & Simpson, 2017; Patel & Simpson, 2010), attrition rate for ERP is around 19.1% (Öst et al., 2015). A qualitative study investigating reasons for OCD treatment non-response from the perspective of the patient highlighted a number of factors perceived to have contributed to difficulties with engaging in CBT and consequent treatment failure (Millar, Salkovskis, Gregory, Halligan, In prep.). Most prevalent were a perceived loss of momentum between weekly therapy sessions; and insufficient time for in-session, *in vivo* ERP, coupled with difficulties in carrying out ERP without therapist assistance (Millar et al., In prep.).

One possible way to tackle problems with therapeutic momentum and limited in-session time for exposure is to deliver an intensive version of CBT, which includes longer therapy sessions delivered over a shorter period. Intensive formats of treatment for OCD are not new; ERP for OCD was first delivered intensively (Meyer, 1966). However, current treatment delivery for OCD in the UK National Health Service (NHS) is predominantly outpatient based and adopts a 50-60 minute therapy session with, on average, 10-12 weekly sessions. The National Institute for Health and Care Excellence (NICE) recommends a more intensive treatment format for those who have not responded to ≥ 2 previous trials of weekly CBT (NICE, 2005). However, OCD patients often continue to receive standard format CBT even after several unsuccessful attempts, rather than being offered intensively delivered CBT

(Millar et al., in prep.). The barriers to intensive format CBT are not well understood, but one key factor is likely to be acceptability; it may be that patients are reluctant to engage with more intensive approaches.

At this stage we know little about patient preferences for OCD treatment delivery format, or the factors that drive those preferences. Although qualitative research has suggested that intensive format CBT for OCD is perceived to be highly acceptable to patients, some concerns were also highlighted and these findings have limited generalisability (Millar et al., in prep; Bevan et al., 2010). Importantly, barriers to initial engagement with intensive CBT have not been addressed. Prospective research with a larger sample is required to more fully understand patient preference with regards to intensive CBT. This is potentially of clinical importance, as choosing or receiving a preferred treatment is associated with increased treatment completion rates, superior clinical outcome and higher treatment satisfaction and adherence (Lindhiem, Bennett, Trentacosta, & McLear, 2014).

Current understanding of the factors that might influence treatment format preferences is also limited. Previous research examining preference of evidence-based treatments for OCD found that being younger, female and experiencing persistent symptoms despite taking SSRIs were each associated with a preference for ERP over medications (Patel et al., 2017). Qualitative research with OCD patients has also highlighted several factors of potential importance to intensive format CBT in particular (Millar et al., in prep). First, from a practical perspective, time and access are important when considering undertaking an intensive treatment. Second, for some patient's intensive format was perceived to have potential therapeutic advantages, particularly in terms of achieving momentum. Third, the experience of previous weekly treatments that had failed to help, was particularly associated with a 'readiness' to try a different therapeutic approach. However, concerns were also highlighted including the intensity and potential for relapse. (Millar et al., in prep). More broadly, factors that have been shown to limit treatment engagement in OCD include severity of OCD symptoms, levels of comorbid depression and general anxiety (Monaghan et al., 2015) and functional impairment (Velloso et al., 2018).

In summary, NICE guidelines recommend intensive CBT for OCD in cases where standard CBT has proved unsuccessful. However, we know little about patient preferences for the delivery format of treatment, in terms of either practical (i.e., accessibility) or therapeutic (i.e., perceived efficacy) considerations. The main aim of the current study therefore, was to conduct an investigation of the preference of individuals with OCD for

intensive versus standard format treatment, and particularly to investigate factors that may influence patient preference. With respect to the latter, we considered a range of potential factors identified in the previous literature, including symptom severity, demographic characteristics and treatment history. We administered a series of online questionnaires to individuals with OCD to examine the perceived therapeutic and practical benefits of intensive versus standard delivery format. We were specifically interested in the following questions:

1. Are participant demographic characteristics associated with treatment format preference, specifically, age, sex, education and employment?
2. Is greater symptom severity (OCD, depression, generalised anxiety) and functional impairment associated with a preference for intensive treatment versus weekly therapy?
3. Is a history of multiple previous experiences of CBT associated with a preference for intensive treatment?
4. Does previous experience of treatment format predict treatment preference?
5. Do high levels of readiness to change result in a preference for intensive treatment format?

Method

Design

A cross-sectional design was utilised. Ethical approval was granted by the University of Bath, Department of Psychology Ethics Committee (Ref. 15-214).

Participants

Participants were recruited via advertisements placed on online OCD forums and on OCD social media platforms. To be eligible for inclusion, participants had to be $\geq$ 18 years of age, identify their main problem as OCD, and meet DSM-5 diagnostic screening criteria for OCD. After incomplete and invalid responses were removed there were 288 useable completed responses. A total of 36 respondents (12.5%) did not identify OCD as their main problem and 17 (5.9%) did not meet diagnostic screening criteria for OCD and were excluded, leaving 235 responses (81.6%) included in the current study.

Measures

OCD Diagnostic Screening Criteria

To screen for the presence of OCD for inclusion in the study, participants were asked 16 questions about the nature of their OCD. Participants were initially asked to describe their main problem followed by a series of questions drawn from the OCD module of the Structured Clinical Interview for DSM-5, adapted to be answered in a self-report format. The response format required participants to respond 'yes/ no' to a series of symptom/interference questions. If the participant responded 'yes', a follow-up question asked them to provide a detailed response. An example question is: "Have you ever been bothered by thoughts, impulses or images that didn't make any sense and that kept coming back to you, even when you tried not to have them?" Yes/ No. "If yes, please briefly state what these thoughts, impulses, images are about". All participant responses were reviewed by a clinical psychologist (JM) experienced in diagnosing OCD, to determine whether they met DSM 5 diagnostic criteria.

Obsessive Compulsive Inventory (OCI) (Foa, Kozak, Salkovskis, Coles, & Amir, 1998).

The OCI is a 42-item self-report measure that assesses the severity of OCD symptoms. Each item is rated on two five-point (0–4) Likert scales which measure the distress and frequency of each symptom. A total score of 42 or more is indicative of OCD. The OCI has been found to have good reliability and convergent validity and differentiates well between individuals with and without OCD (Foa et al., 2002). As is standard, in the current study the total index of distress was used as the main outcome (Cronbach's α = .94).

Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001).

The PHQ-9 is a nine item self-report measure of depressive symptom severity. Each of the diagnostic criteria for depression is scored from '0' (not at all) to '3' (nearly every day). Total scores range from 0-27; with recommended cuts-offs as follows: 0-4 none or minimal; 5-9 mild; 10-14 moderate; 15-19 moderately severe; 20-27 severe depressive symptoms. The PHQ-9 has been found to be a reliable and valid measure of depression severity, internal consistency α= .89 (Kroenke et al., 2001). In the current study, internal consistency was α = .90.

General Anxiety Disorder Assessment (GAD-7) (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

The GAD-7 is a seven item self-report measure of GAD symptom severity. The scale ranges from '0' (not at all) to '3' (nearly every day). Total scores range from 0-21 and recommended cut-offs are as follows: 0-4 minimal; 5-9 mild; 10-14 moderate; 15-21 severe. The GAD-7 has been found to have excellent internal consistency (α = .92) good reliability, as well as criterion, construct, factorial, and procedural validity (Kroenke et al., 2007). Internal consistency in the current study was α = .91.

Work and Social Adjustment Scale (WSAS) (Mundt, Marks, Shear, & Greist, 2002).

The WSAS is a 5 item self-report measure that examines an individual's level of impairment in functioning. The scale ranges from '0' (not at all) to '3' (nearly every day). The scale has good reliability and validity, with internal consistency ranging from α = .70 to α= .94. It has been found to be sensitive to patient differences in disorder severity and treatment related change (APA, 1994; Mundt et al., 2002). In the current study, internal consistency was α = .83.

Treatment preference questionnaire (TPQ).

The Treatment Preference Questionnaire (TPQ) was devised for this study to explore participants' preferences regarding the format of CBT delivery (i.e., weekly or intensive). First, participants were provided with definitions of weekly and intensive CBT formats. For the purposes of this study, weekly was defined relative to UK standard practice, i.e., CBT delivered once per week for 60 minutes, for approximately 12-15 weeks, with three, 60-minute booster sessions offered at monthly intervals post treatment (Oldfield, Salkovskis & Taylor, 2011). Intensive format was defined as 12-15 hours of CBT with all treatment taking place over three weeks, which is consistent with definitions in the literature (Abramowitz, Foa, & Franklin, 2003; Jónsson et al., 2015). Intensive format CBT was also described as including three 60-minute booster sessions offered at monthly intervals post treatment.

After reading these definitions, participants responded to 19 questions regarding their treatment preferences. Items were based on the results of a qualitative studies which examined participants' views on why their previous CBT for OCD had been unsuccessful as well as the prospect of an intensive version of CBT from the perspective of the patient and therapist. Participants identified factors related to therapeutic content and process, as well as

accessibility (Millar et al., in prep). Thus, the resultant scale captured both therapeutic and practical considerations. An example statement and response format is:

'I believe there would be more time to focus on doing things to actively tackle my OCD IN the therapy session, IF CBT was delivered:

Weekly				**Intensively**		
Definitely	**Moderately**	**Slightly**	**No difference**	**Slightly**	**Moderately**	**Definitely**

Participants rated each statement from 1 (indicating a strong endorsement for weekly format) to 7 (endorsement of intensive format), with a score of 4 being no difference. Thus, scores greater than 4 indicate an increased preference for intensive CBT (i.e., slightly = 5, moderately = 6, definitely intensive = 7) and scores below 4 indicate a preference for weekly CBT (i.e., definitely weekly = 1, moderately = 2, slightly = 3).

The 19 items of the TPQ were subjected to a principal components analysis with varimax rotation in order to define the dependent variables. The factor analysis initially identified three components; however, one component was not usable as it contained only two items. These two items were removed. A further item was also removed as it had a low loading on all factors. The principal components analysis with varimax rotation was then rerun without the aforementioned variables. Table 1 provides the details of the two components identified, the corresponding eigenvalues, variance explained and internal consistency (Cronbach's Alpha). The first component is 'therapeutic preference' consisting of 10 items (capturing factors that pertain to effective therapy, such as; being committed and able to focus on therapy, actively tackling OCD within sessions and autonomously, maintaining momentum). The second component is 'practical preference', which consists of six items (capturing factors that would facilitate engagement from a practical perspective such as; how the format would fit with participants schedule/ lifestyle, engaging with tasks within and between therapy sessions). A subset of participants (n = 97) recompleted the questionnaire two weeks after the completion of the first set of questions. Test-retest reliability for the therapeutic preference subscale was r = .873, n = 97, p <.01 and for the practical preference subscale r = .869, n = 97, p <.01.

Table 1.

Pattern/ Structure coefficients for Treatment Preference Questionnaire with varimax rotation of two factor solution.

Item	Component 1	Component 2
9. I believe I would be able to focus more fully on CBT for my OCD if the treatment was delivered:	**.826**	.252
8.I believe that the momentum in therapy would be best maintained if therapy was delivered:	**.801**	.285
7. I believe CBT is likely to have a more powerful effect if it is delivered:	**.799**	.366
19. I believe CBT would be the most effective if it is delivered:	**.773**	.446
15.I believe I would feel more committed to CBT if it was delivered:	**.746**	.383
13.I believe my therapist would have more time to focus on me and my progress if CBT was delivered:	**.736**	.228
6.I believe there would be more time to focus on doing things to actively tackle my OCD IN the therapy session, IF CBT was delivered:	**.669**	.344
17.I believe I would feel more motivated to undertake CBT if I was offered it:	**.667**	.483
10.I believe I would be LESS LIKELY to forget the information in-between therapy sessions if CBT was delivered:	**.656**	.129
18.I believe I would be LESS LIKELY to relapse if treatment was delivered:	**.651**	.421
12.I believe it would be easiest for me to make time in my life to undertake CBT if it was delivered:	.173	**.838**
1.I believe that practically it would suit my lifestyle better if treatment was delivered:	.286	**.798**
16.I believe it would be easier for my family member/ loved one to be involved in the treatment process (if I wanted them to be) if the treatment was delivered:	.221	**.734**
11. I believe I would have enough time IN-BETWEEN sessions to practice what I had learnt if treatment was delivered:	.393	**.714**
5.I believe I would be more likely to complete and learn from my homework in-between sessions if CBT was delivered:	.398	**.665**
3.I believe time for me to practice the tasks within the therapy session with the therapist would be ideal if it was delivered:	.389	**.606**
Eigenvalues	9.063	1.385
% of variance	56.64	8.65
a	.940	.881

OCD Desire-to-Change Questionnaire

The OCD Desire-to-change Questionnaire is a 13 item self-report questionnaire which was adapted from the Hoarding Desire-to-Change Questionnaire (Lambe & Salkovskis, 2015) which has good internal consistency (α = .81). The questionnaire has three subscales: 1. 'Problem recognition' (4 items) which assesses the extent to which an individual perceives their OCD to be problematic (e.g., 'I think I am too preoccupied by my OCD fears'), 2. 'Desire-to-change' (4 items) (e.g., 'I wish I was free of OCD') and 3. 'Action towards change' (5 items) (e.g., 'I have recently confronted more of my OCD fears'). Participants are asked to rate how much they believe each statement on a scale from '0' (I do not believe this idea at all) to '100' (I am completely convinced this idea is true). The possible range of scores was 0 to 100. In the current study, the internal consistency for the overall scale was good (α = .80) (subscales: Problem recognition α = .77; Desire-to-change α = .81; Action towards change α = .80). A subset of participants (n = 92) recompleted the questionnaire after two weeks. Test-retest reliability was excellent; total score, r = .874, n = 92, p <.01; Problem recognition, r = .806, n = 92, p <.01; Desire-to-change, r = .863, n = 92, p <.01; Action towards change, r = .885, n = 92, p <.01.

Procedure

Participants who responded to an online study advertisement link were directed to the online questionnaire portal. At the study site, potential participants were asked to read an information sheet and were provided with the researcher's contact details to ask questions or seek further information if they wished. Informed consent was obtained via an online consent form. Following this, participants were asked to complete a series of questionnaires. On completion, participants had the option of entering a prize draw. Following this, all participants were invited to take part in an extension of the study, which involved completing two of the study measures again two weeks later (i.e., TPQ and Desire-to-change questionnaire). Participants received a £5 electronic voucher for completing the extension.

Data Analytic Plan

Statistical analyses were performed using SPSS 25.0. Preliminary analyses explored descriptive information for the sample including the primary questions on treatment format preference. The relationships between demographic variables and the two dependent variables, 'Therapeutic preference' and 'Practical preference', were examined using Pearson product-moment correlation coefficient for age and multivariate analysis of variance (MANOVA) for sex, education and employment. Education level was dummy code as: 1 =

High school incomplete; 2 = High school/ diploma complete; 3 = University degree; and employment status was coded as 1 = unable to work due to OCD severity; 2 = part-time or flexible working arrangements (e.g., student, home duties, carer, retired); 3 = full-time employed. Correlational analyses were used to examine the relationship between treatment preference and both psychological variables (including symptom severity/desire-to-change and number of previous sets of CBT. MANOVA was used to examine the relationship between previous experience of treatment format (coded as 0 = none, 1 = weekly CBT, 2 = intensive CBT) and treatment preference scores.

Results

Sample description

Descriptive data for the sample are presented in Table 2. The majority of participants were female, of white ethnic origin, and well educated. Over half of the sample were employed whilst a fifth were unable to work due to the severity of their OCD. Mean sample OCD symptom severity as measured by the OCI distress scale was well over the clinical cut-off of 42, indicating a significant level of distress. Participants, on average, were also in the moderate range of severity for both depression and generalised anxiety symptoms. The average score on the WSAS was over 20, which indicates moderate to severe functional impairment.

Participants reported a mean age of OCD onset in early adolescence, with OCD significantly interfering in their lives approximately seven years later. Participants, on average, waited a further five years before seeking help for their OCD and did not receive help specifically for OCD until a further two years later. Half of the participants were initially offered CBT for OCD, whilst a quarter were initially offered medication. The majority of participants had already experienced CBT delivered in a weekly format; a minority had received intensive format CBT or had no prior experience of psychological intervention (see Table 2 for details).

On average, participants, strongly recognised that their OCD was problematic and reported a very high desire-to-change. However, participants' current actions to overcome their OCD were more moderate.

Table 2.

Participant characteristics and treatment history

Demographics		***N* (%)**
Gender	Male	63 (26.8)
	Female	171 (72.8)
	Gender non-binary	1 (.4)
Ethnicity	Asian & Black African	22 (9.4)
	White	213 (90.6)
Education	School not complete	26 (11.1)
	High school completed	35 (14.9)
	Diploma	21 (8.9)
	Undergraduate degree	75 (31.9)
	Postgraduate degree	78 (33.2)
Employment	Unable to work due to OCD	48 (20.4)
	Student	36 (15.3)
	Employed part-time	36 (15.3)
	Employed full-time	98 (41.7)
	Other (carer, retired)	17 (17.2)
Symptom Severity		***M* (*SD*)**
Current Age		35.12 (11.81)
OCI		70.16 (28.81)
PHQ-9		12.39 (6.74)
GAD-7		12.19 (5.71)
WSAS		21.89 (8.19)
Desire-to-change		
Problem recognition		29.68 (9.61)
Desire-to-change		38.20 (7.64)
Action towards change		37.80 (12.16)
History of OCD & treatment		
Duration of OCD		15.9 (11.81)
Age of onset		12.32 (6.91)
Age significantly interfered with life		19.09 (8.84)
Age found out that problem was OCD		23.52 (10.10)
Age first sought help		24.18 (9.94)
Age first offered treatment for OCD		26.72 (2.51)
Treatment first offered for OCD		
	CBT or ERP or CBT including ERP	121 (51.4)
	Counselling	29 (12.3)
	Psychodynamic	5 (2.1)
	Systemic	3 (1.3)
	Medication	60 (25.5)
	Never sought help	10 (4.3)
Number of past sets of CBT		2.39 (2.24)
Experience of treatment formats		***N* (%)**
	No Psychological therapy	31 (13.2)
	Experience of weekly CBT	158 (67.2)
	Experience of Intensive CBT	46 (19.6)

N = Number of participants; *M* = Mean; *SD* = Standard deviation; OCI = Obsessive Compulsive Inventory (Distress); PHQ-9 = Patient Health Questionnaire; GAD-7 = Generalised Anxiety Disorder; WSAS = Work and Social Adjustment Scale.

Treatment Preferences

When participants were asked which format in general, they would prefer to receive CBT, 51.4% (*n* = 121) reported weekly; 40.4% (*n* = 95) intensive and 8.1% (*n* = 19) did not have a preference. For the two subscales of the treatment preference questionnaire participants indicated on average that they slightly preferred a weekly format with regards to 'practical preference' (*M* = 3.21, *SD* = 1.74; one tailed *t*-test shows significantly different to the 'no preference' score of 4, *t* = -6.97, *df* = 234, *p* < .001), but intensive format was slightly preferred with regards to 'therapeutic preference' (*M* = 4.37, *SD* = 1.77; one tailed *t* = 3.13, *df* = 226, *p* = .002).

What participant characteristics predict treatment preference?

Demographics.

Bivariate correlations were used to examine associations between age and TPQ scores. There was a small positive correlation between participants' current age and practical preference, with being older being positively associated with preference for intensive CBT (*r* = .18, *n* = 235, *p* = <.01), but there was no equivalent effect for therapeutic preference (*r* = .095, *n* = 227, *p* = .154).

A series of multivariate analyses of variance (MANOVA) were performed to investigate the relationship between sex, education and employment status (independent variables) and TPQ scores (dependent variables; therapeutic preference and practical treatment preference). For sex, a MANOVA found no multivariate effect in relation to TPQ scores *F*(2, 223) = .47, *p* = .63.

For education (high school incomplete, high school/ diploma complete, university degree), there was a small multivariate effect with respect to TPQ scores, *F*(4, 448) = 2.67, *p* = .032; Pillai's Trace = .05; partial eta squared = .02. Univariate analyses further identified that education effects were present for practical preference subscale scores, *F*(2, 224) = 4.02, *p* = .019, partial eta squared = .035, with no significant effect for therapeutic preference scores *F*(2, 224) = .44, *p* = .642. Post-hoc comparisons using LSD test indicated that the mean practical preference score for participants who had not completed high school (*M* = 4.17, *SD* = 2.01) was significantly higher than for those who had completed high school/ diploma (*M* = 3.23, *SD* = 1.68, *p* = .026) and those with a university degree (*M* = 3.09, *SD*

= 1.71, p = .005). Thus, overall, more highly educated participants showed a stronger preference for weekly format CBT from a practical preference perspective. However, there was no effect of education in relation to therapeutic preference.

For employment status (unable to work due to OCD, flexible employment, full-time employment) there was a small multivariate effect with respect to TPQ scores, $F(4, 448) = 2.80$, p = .026; Pillai's Trace = .05; partial eta squared = .02. Univariate analyses further identified that employment status effects were present for practical preference subscale scores, $F(2, 224) = 4.19$, p = .016, partial eta squared = .04, with no significant effect for therapeutic preference scores, $F(2, 224) = .526$, p = .592. Post-hoc comparisons using LSD test indicated that the mean practical preference score for participants who were unable to work due to the severity of their OCD (M = 3.90, SD = 1.89) was significantly higher than those in both the flexible working group (M = 3.01, SD = 1.58, p = .005) and the full-time working group (M = 3.15, SD = 1.76, p =.018). In sum, participants in employment showed a stronger preference for weekly CBT than those who were unable to work due to their OCD from a practical preference perspective, with no equivalent effect present for therapeutic preference.

OCD characteristics, depression, generalised anxiety and functional impairment.

Bivariate correlations were used to examine associations between OCD severity, duration of OCD, depression, generalised anxiety, level of functional impairment and TPQ scores. There was no relationship between OCD severity or duration of OCD for either practical (severity r = - .025, n = 207, p = .718; duration r = .096, n = 235, p = .141) or therapeutic preference (severity r = .016, n = 200, p = .825; duration r = .062, n = 227, p = .353, respectively). Neither was there a relationship between level of depressive symptomology and practical (r = .093, n= 218, p = .171) or therapeutic preference (r = .088, n= 211, p = .205). There was a small, positive correlation between level of generalised anxiety and therapeutic preference (r = .181, n= 219, p = <.01) with higher levels of generalised anxiety associated with a stronger preference for intensive CBT, but there was no equivalent effect for practical preference (r = .107, n = 227, p = .108). By contrast, for level of functional impairment there was a small positive correlation between WSAS scores and practical preference (r = .179, n = 233, p < .05) with higher levels of impairment associated with marginally greater practical preference for intensive CBT, but there was no equivalent effect for therapeutic preference (r = .089, n = 225, p = .182). Thus, overall, those with higher general anxiety symptoms tended to show a preference for intensive CBT from

a therapeutic perspective and those with greater levels of functional impairment showed a preference for intensive from a practical preference perspective.

Treatment History.

Bivariate correlations were used to examine associations between previous number of sets of therapy experienced and TPQ scores. There was a small positive correlation between the previous number of sets of therapy experienced and practical preference for treatment (r_s = .119, n = 235, p <.05), with prior experience of more sets of therapy being associated with a slightly greater practical preference for intensive CBT, but there was no equivalent effect for therapeutic preference (r_s = .085, n = 227, p = .101).

MANOVA was performed to investigate the relationship between previous experience of therapy format (no previous psychological therapy, weekly, intensive, as independent variables) and TPQ scores (i.e. therapeutic preference and practical preference). There was a statistically significant multivariate effect of previous therapy format with respect to TPQ scores F (4, 448) = 3.02, p = .018, Pillai's Trace = .05; partial eta squared = .03. Univariate analyses further identified that effects of experience of previous therapy format were present for both therapeutic preference subscale scores F (2, 224) = 5.78, p = .004 and practical preference subscale scores F (2, 224) = 4.65, p = .011. Post-hoc comparisons using LSD tests indicated that participants who had previously experienced an intensive treatment had significantly higher scores on therapeutic preference (M = 5.10, SD = 1.59) in comparison to participants who had previously experienced weekly treatment (M = 4.25, SD = 1.80, p = .008) and no psychological therapy (M = 3.83, SD = 1.62, p = .008). The same pattern was evident for practical preference, with those who had experienced intensive CBT (M = 3.90, SD = 1.66) compared to weekly (M = 3.12, SD = 1.80, p = .004) and no psychological treatment (M = 2.21, SD = 1.40, p = .002). Thus, participants who had previously experienced intensive treatment showed a relatively greater preference for intensive CBT from both a therapeutic preference and a practical preference compared to those who had not previously experienced an intensive format. However, it should be noted that all practical preference scores were below 4 and therefore favoured weekly format.

Desire-to-change score.

Bivariate correlations were used to examine associations between the three Desire-to-change subscales (i.e., desire-to-change, problem recognition, action towards change) and TPQ scores. There was a small significant correlation between desire-to-change and both practical preference (r = .17, n = 232, p <.01) and therapeutic preference (r = .16, n = 224, p <.05), with greater desire-to-change associated with a slightly increased preference for

intensive CBT. Problem recognition was significantly correlated with practical preference (r = .21, n = 232, p <.01) with participants who had higher levels of problem recognition having a slightly higher preference for intensive CBT, but there was no equivalent effect for therapeutic preference (r = - .12, p = .06). There was no relationship between action towards change scores on either practical (r = - .07, p = .313) or therapeutic preference (r = - .002, p = .978). Thus, overall, those with a greater desire-to-change tended to prefer an intensive format from both a practical and therapeutic perspective, whilst those with higher levels of problem recognition showed a preference for an intensive format from a practical perspective only.

Discussion

In a large sample of individuals with moderate to severe self-rated OCD and high levels of impairment, we examined preferences regarding the delivery format of CBT (i.e. weekly or intensive formats) from both a therapeutic and practical perspective. As a whole, the sample showed a marginal preference for weekly versus intensive CBT from a practical perspective but rated intensive format CBT as having slightly better therapeutic benefits. When predictors of format preference were examined, a stronger preference for intensive format from a practical perspective was associated with not being in full-time employment, having lower levels of education, higher levels of functional impairment, a more extensive previous treatment history, prior experience of intensive CBT and a stronger desire-to-change. By contrast only prior experience of intensive CBT, higher levels of general anxiety and a greater desire-to-change predicted greater perceived therapeutic benefits of intensive versus weekly format CBT.

Overall there was a slight tendency for participants to prefer weekly format CBT from a practical perspective. This observation runs counter to suggestions that the opportunity to receive treatment in a relatively short block of time is a key selling point of intensive CBT, as the logistics of taking time out for treatment are simpler (Bevan, Oldfield, & Salkovskis, 2010). However, it is consistent with previous research examining therapists' views on intensive CBT, in which therapists proposed that intensive CBT may be more practically difficult for patients to incorporate into their lives (Millar et al., in prep). It should be noted that being younger, better educated, in full-time employment and showing lower levels of functional impairment were each associated with a stronger practical preference for weekly versus intensive CBT. This pattern overall is consistent with the need to take time out of work/other commitments to engage with intensive treatment being an obstacle to engagement. Intensive formats may be particularly suited to those who can be more flexible

with their time; or for those who are geographically distant from treatment facilities; or require treatment within a short time frame (e.g. perinatal circumstances), possibilities which were not specifically examined within this study. It is of note that in the current study the intensive format was presented as CBT delivered twice a week over a three-week period. It is possible that a more condensed version (i.e., delivery over one or two weeks) may be more practical for those in employment who have limited holidays, and this needs further investigation.

A second key finding of the current study was that prior experience of multiple sets of weekly CBT was associated with a slightly stronger practical preference for intensive CBT. This finding is in line with the NICE guidance which identifies this group of patients as the key target group for which intensive treatment is recommended. The pattern of preference for intensive format was also evident from both a therapeutic and practical perspective for those who had previously undertaken intensive CBT. This suggests that the somewhat stronger preference for an intensive format in this group is due to more than just a desire to try a new treatment approach. It is also consistent with previous qualitative research, which suggests that after engagement with intensive format CBT, OCD sufferers perceive this delivery format highly positively. Previous research indicates that therapeutic benefits of intensive format are perceived to include increased therapeutic momentum and a greater capacity to engage in within-session ERP, according to both therapists and OCD suffers. It is particularly encouraging in the current study that the NICE identified target group for intensive intervention is more likely to have positive perceptions of this delivery format. Nonetheless, very few participants in the current study had engaged with intensive CBT, and there remain service level barriers that would also need to be overcome to ensure more widespread delivery.

Previous qualitative research suggests severity and duration of symptoms may lead people to prefer an intensive format, due to the opportunity to tackle OCD in a more supported, concentrated way with in-session therapist support (Millar et al., in prep). However, in the current study there was no relationship between severity of OCD symptoms or duration of illness and treatment preference. Desire-to-change was associated with a greater preference for intensive CBT, from both a practical and therapeutic preference. This suggests that those with the strongest motivation to achieve recovery are likely to engage particularly well with CBT in intensive format.

The current findings should be considered in the light of some limitations. All data were collected online, meaning that participants identified themselves as having OCD as

their main problem and thus self-selected to complete the online questionnaire. However, diagnostic screening questions linked closely to DSM-5 OCD criteria were utilised along with the OCI, with responses reviewed carefully, thus we can be certain that a valid OCD population was recruited. The self-report measures utilised were initially validated for paper administration; however, research supports the comparability of internet administration and paper administration on a number of OCD symptom related measures (Coles, Cook, & Blake, 2007). In addition, as already discussed, we provided a definition of intensive CBT which was consistent with clinical practice but does not represent a more condensed format. A different pattern of findings may have emerged given a different definition of the intensive format.

Our findings highlight the importance of employment status, past experiences and frequency of previous courses of CBT as well as an individual's problem recognition and desire-to-change as factors that influence preference for the delivery format of CBT and may be important to consider clinically. Our results support the current NICE guidance for intensive treatment, insofar as OCD patients with previous experience of CBT were particularly likely to view this format positively. Future research should investigate if assessing treatment preference and incorporating this into the choices offered to patients has an impact on treatment outcome and adherence. This should be done with participants who have previously experienced $\geq$ 2 previous courses of CBT for OCD.

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CHAPTER 10: STUDY 6

The Story of The Wolf in Sheep's Clothing: Relapse in Obsessive Compulsive Disorder

"Relapse is one of my biggest fears. It's probably understandable, but if I am having a bit of a bad day I can catastrophize quite quickly and be like, oh no, I didn't sleep well, things are feeling more difficult, I don't want to go back to square one"
(OCD participant- Study 6).

Chapter Rationale

The first few chapters in the present thesis indicate that there are shortcomings in the otherwise effective treatment for OCD, something that may at least in part be due to delivery and format issues rather than fundamental problems with CBT. As such, the studies of this thesis have had intensive treatment as their main focus when considering CBT for OCD. Specifically, a format that is condensed in terms of the time period over which is it is delivered in longer sessions (typically several days). With this treatment format, it seems likely that good acute and short-term response would be the result; however, of equal or greater importance is the longer-term outlook both in terms of continued wellbeing and resistance to relapse.

In the systematic review (Chapter 4) it was noted that there were few studies of intensive format CBT for OCD, although those that were found, were promising in terms of outcomes. However, the reviewed studies reported minimal follow-up and are thus not sufficient to enable comment on the longevity of reported effects.

In Chapter 6: Study 3 regarding intensive treatment, most participants indicated that it would be attractive to them, but they had reservations. One of the concerns raised about intensive treatment was that, if it all happened very quickly, then gains made may also evaporate equally quickly. Similar concerns were noted in the following chapter which focused on therapists' perspectives of intensive treatment.

The studies of this thesis indicate that if intensive treatment were to be more commonly used, one of the major concerns is that the benefits might not persist. This leads us to consider issues around relapse in individuals who have had either intensive or weekly CBT. There is very little literature on how and why relapse occurs. This final chapter therefore considers the experience of relapse from the perspective of the service user.

This declaration concerns the article entitled:			
The Story of the Wolf in Sheep's Clothing: Relapse in Obsessive Compulsive Disorder.			
Publication status (tick one) **Draft manuscript** [x] **Submitted** [ ] **In review** [ ] **Accepted** [ ] **Published** [ ]			
Publication details (reference)	Millar, J.F.A. and Salkovskis, P.M.		
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Candidate's contribution to the paper (provide details, and also indicate as a percentage)	Josie Millar made considerable contributions to the conception of the study (90%), as well as the methodological design (90%). The research process, including the acquisition of and analysis of data was predominantly conducted by Josie (90%). Josie also primarily executed the presentation of the study and associated data in journal format (90%).		
Statement from Candidate	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature.		
Signed		**Date**	27.09.2019

The Story of the Wolf in Sheep's Clothing: Relapse in Obsessive Compulsive Disorder

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Abstract

Background: While the short-term efficacy of Cognitive Behavioural Therapy (CBT) for Obsessive Compulsive Disorder is well established, issues surrounding longer term outcomes and the persistence of gains made during treatment have been less thoroughly investigated. It is well known that a significant proportion of patients relapse after CBT for OCD. The research examining reasons for relapse has thus far been undertaken from a therapist perspective. The aim of this study was to explore the factors service users identified as being linked to relapse.

Method: Twenty-seven semi-structured telephone interviews were conducted with participants with OCD. All participants had previously experienced ≥ 2 unsuccessful courses of CBT, however had also experienced a successful course of CBT followed by a relapse. Interviews were analysed using thematic analysis.

Results: Participants reported a range of stressors as well as cognitive and behavioural patterns as being linked to relapse. Participants also identified the use of relapse prevention and follow-up sessions as instrumental in preventing relapse. Four overarching themes were identified: 1) When stress is here, OCD is near, 2) Five slippery slopes to relapse, 3) Factors related to therapy and 4) Sadness and fear: emotional responses to relapse.

Conclusion: Clinically effort should be directed towards working with patients to consolidate gains in therapy. Time in therapy should also be spent on developing an idiosyncratic relapse prevention plan before the completion of therapy. Booster or follow-up sessions should be offered as an additional form of relapse prevention. Further clinical implications and future research directions are discussed.

Key words: Obsessive Compulsive Disorder, OCD, Relapse, Relapse Prevention, Intensive Cognitive Behavioural Therapy, CBT, Follow-up.

Background

The effectiveness of Cognitive Behavioural Therapy (CBT) that includes Exposure and Response Prevention (ERP) for Obsessive Compulsive Disorder (OCD) is one of the most consistent findings in research and clinical settings (Abramowitz & Arch, 2014; Öst et al., 2015). However, as McManus, Grey, and Shafran (2008) highlighted over a decade ago, on completion of treatment and at follow-up many patients have still not achieved high levels of functioning. This emphasised the room for improvement then, which remains the case for OCD now. Despite the clear evidence of short term treatment success, full relapse following CBT is reported to occur for at least 20% of patients (O'Neill & Feusner, 2015). Across studies, rates of relapse are reported to range from 20 to 60% following CBT (Eisen et al., 1999; Marcks, Weisberg, Dyck, & Keller, 2011) and up to 90% following discontinuation of pharmacological interventions (Braga, Manfro, Niederauer, & Cordioli, 2010). It is suggested that such variability may be due to a lack of standardised relapse criterion (Simpson, Franklin, Cheng, Foa, & Liebowitz, 2005) or the heterogeneity of the disorder (Eisen et al., 2013). Whatever the precise figure, it is clear that a large proportion of participants experience a relapse following treatment for OCD.

Randomised Controlled Trials (RCTs) are generally carried out to measure efficacy in terms of acute response, and are therefore limited in their capacity to provide information on the long-term duration of treatment effect and rates of remission (Burchi, Hollander, & Pallanti, 2018). There are of course questions about what "treatment response" actually means. Within the context of the OCD treatment literature, 'response' denotes short-term improvement in symptoms generally represented by a 25% - 35% reduction in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989; Burchi et al., 2018). It should be noted that statistically significant change and clinically significant change are not synonymous and at this level of 'response' patients can still be burdened with high levels of impairment (Farris et al., 2013; Macy et al., 2013). Burchi and colleagues (2018) define 'remission' as a reduction of symptoms to below diagnostic threshold for a period of at least 12 weeks and 'recovery' as sustained remission measured by a duration of two years, with the individual returning to premorbid levels of functioning. Here we have chosen to regard response as meaningful improvement as self-defined by those who received treatment.

Since the development of effective treatments for OCD, very few prospective studies have examined long-term outcomes. To date, Eisen and colleagues (2013) have conducted the largest (N = 213) prospective observational study comprising individuals with primary OCD. Over five years, 21.1% of the sample had a partial remission and 16.9% a full

remission. Of those who remitted or partially remitted, 59% subsequently relapsed. The likelihood of relapse was 25% higher for participants who had a partial remission compared to a full remission (70% vs. 45% respectively). These findings emphasise the importance of the target of treatment being full remission from OCD, rather than improvement of symptoms. The only other predictor of relapse was the comorbidity of Obsessive-Compulsive Personality Disorder (OCPD); these patients were found to be twice as likely to relapse (Eisen et al., 2013). This may indicate some diagnostic confusion.

Additionally, Braga et al. (2010) conducted a two year follow-up study after a group CBT intervention with a smaller sample (N = 42). At the end of the intervention a full remission was reported by 21.4% and partial remission by a further 52.4%. Full remission of symptoms was a significant protective factor against relapse. At two years none of those who had achieved full remission had relapsed. However, 41.9% of those who had achieved partial remission had relapsed, with 85% of these occurring in the first year post treatment. These findings suggest that patients who achieve only partial remission should be further supported particularly within the first year.

Given the high rates of relapse it is remarkable that the literature regarding approaches to relapse prevention for OCD is incredibly sparse. Hiss, Foa and Kozak (1994) randomised patients to either receive a relapse prevention program (RPP) or active control post intensive ERP for OCD. At the six-month follow-up they found that 75% of the RPP group had maintained their gains in comparison to 33% of the control condition. The RPP group were also found to be significantly less depressed and anxious. This study was conducted 25 years ago yet little has changed in the field, and relapse prevention programs are not a part of standard clinical practice or recommended as such within clinical guidelines. Within the NICE guidelines follow-up is only recommended at the final level of stepped care where an intensive intervention or inpatient treatment is recommended for those who have experienced multiple treatment failures (NICE, 2005). However, from a service user perspective, follow-up after the completion of CBT regardless of how many previous courses of CBT have been undertaken, is reported to be of great value and considered integral to maintaining gains and prevention of relapse. It is reported to be widely sought but seldom received (Millar et al., in prep).

There have been no in-depth studies investigating relapse from the perspective of the OCD sufferer. Such studies, evaluating the reasons individuals perceive they relapsed after successful treatment will help to identify potential interventions, which could mitigate relapse after successful and partially successful treatments. In the present study, we are

focussed on examining the experience of service users who have previously had ≥ 2 treatment failures, followed by a course of CBT which was successful, undertaken in either an intensive or weekly format, but later experienced a relapse. Contrasting participants whose successful treatment has been undertaken either intensively or weekly will allow us to examine if any factors identified may be unique to the format of delivery. The aims of this study are to explore participants' experiences of relapse, the factors identified as being linked to relapse, and to investigate whether relapse experiences differed for those who had intensive CBT vs. those who had weekly CBT.

The specific research questions explored were:

1. What factors do participants identify as linked to relapse?
2. Are there specific factors relating to the therapeutic process or content of therapy that participants perceive to be associated with relapse?
3. Is the experience of those who have relapsed following intensive CBT different to those who have relapsed after weekly CBT?

Method

Design

Qualitative methodology was chosen as the most suitable approach for exploring service users' experience of relapse after successful CBT.

Participants and Recruitment

Participants were eligible if they were ≥18 years, met diagnostic criteria for OCD (as specified by the Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5) (APA, 2013), identified OCD as their main problem, had experienced ≥ 2 previous CBT failures, followed by successful CBT, followed by a relapse. Purposive and snowball sampling techniques were used to recruit participants. Participants were recruited via adverts placed on social media sites, the websites of UK OCD charities and from attendance at OCD service users' national conferences. Three participants who were screened as eligible to take part were excluded from the study after the interview had been completed. During the interview they described a partial response, although they perceived that all of their treatments had been unsuccessful.

Measures

Structured Clinical Interview for DSM-5 Disorders (SCID-5) (First, Williams, Karg, & Spitzer, 2015).

To confirm OCD diagnosis, participants were administered the OCD relevant section of the SCID-5, a clinician administered diagnostic interview that is used to determine DSM-5 disorders, reported to have acceptable reliability and validity (First et al., 2015).

Obsessive Compulsive Inventory (OCI) (Foa, Kozak, Salkovskis, Coles, & Amir, 1998).

This 42-item self-report measure assesses severity of OCD symptoms. Items are rated on two five-point (0–4) Likert scales, which measure the distress and frequency of each symptom. A total score of 42 or more is indicative of OCD. The OCI has been found to have good reliability and convergent validity (Foa et al., 1998). As is standard, only the total index of distress was used in the current study (Cronbach's α = .95).

Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001).

The PHQ-9 is a nine item self-report measure of depressive symptom severity. Each diagnostic criteria for depression is scored from '0' (not at all) to '3' (nearly every day). Total scores range from 0-27; with recommended cuts-offs as follows: 0-4 none or minimal; 5-9 mild; 10-14 moderate; 15-19 moderately severe; 20-27 severe depressive symptoms. The PHQ-9 has been found to be a reliable and valid measure of depression severity, internal consistency α = .89 (Kroenke et al., 2001). In the current study, internal consistency was α = .96.

General Anxiety Disorder Assessment (GAD-7) (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

The GAD-7 is a seven item self-report measure of GAD symptom severity. The scale ranges from '0' (not at all) to '3' (nearly every day). Total scores range from 0-21 and recommended cut-offs are as follows: 0-4 minimal; 5-9 mild; 10-14 moderate; 15-21 severe. The GAD-7 has been found to have excellent internal consistency (α = .92), good reliability, as well as criterion, construct, factorial, and procedural validity (Kroenke et al., 2007). Internal consistency in the current study was α = .88.

Work and Social Adjustment Scale (WSAS) (Mundt, Marks, Shear, & Greist, 2002).

This five item self-report measure examines an individual's level of impairment in functioning. The scale ranges from '0' (not at all) to '3' (nearly every day). The scale has

good reliability and validity, with internal consistency ranging from α = .70 to α = .94. It has been found to be sensitive to patient differences in disorder severity and treatment related change (Mundt et al., 2002). In the current study, internal consistency was α = .91.

Qualitative Interviews[12]

A semi-structured interview was developed by the authors who are clinical psychologists experienced in the treatment of OCD, in collaboration with an individual with personal experience of CBT for OCD. Questions were designed to be a starting point for discussion and elaboration (Forrester & Sullivan, 2018). Participants were asked to describe their treatment history and to talk about the therapy that had been successful and their subsequent relapse. The semi-structured interview was piloted with a person with personal experience of OCD. In response to the pilot interview, additional optional prompts were added. During the interview the researcher encouraged participants to elaborate on their answers, provided prompts and sought clarification where necessary. Participants were invited to ask questions throughout the interview and on its conclusion.

Procedure

Ethical approval was granted by the University of Bath Research Ethics Committee (17-304). Participants who contacted the researcher to express an interest in participating were contacted by phone to discuss the study and assess their eligibility to take part. If the participant met inclusion criteria, they were emailed a personal link, which directed them to an online questionnaire portal for completion of the study measures. Firstly, potential participants were asked to read an information sheet and informed consent was obtained via an online consent form. Participants were then asked to complete the series of questionnaires. A time for the interview was then scheduled. Individual interviews were conducted by telephone and lasted approximately 60 minutes (range 24 - 94 minutes). All interviews were recorded using a digital voice recorder and were transcribed verbatim, with identifying information removed and pseudonyms inserted. If participants requested further support, they were signposted to appropriate resources. On completion participants received a £5 electronic voucher in appreciation for their time.

Data Analytic Strategy and Approach

The data set comprised 27 completed questionnaires and transcribed interviews. Clinical characteristics of the sample were summarised utilising descriptive statistics.

[12] The semi-structured interview schedule is available from the corresponding author on request.

Thematic analysis was chosen to analyse the interview transcripts, as this approach is well suited to exploring individuals' experience. The six phase process outlined by Braun and Clarke (2006; 2013) was followed. The first author read the interview transcripts three times each to familiarise herself with the data. Following this the transcripts were then systematically coded. The data were approached from an critical realist perspective, which assumes that the data represent a valid report of the participant's reality, explained by the way in which the participant talks about their experiences and the meaning this has for them. The analysis was initially conducted by the first author, a clinical psychologist experienced in the treatment of OCD. An inductive approach was utilised, and thus the data was the starting point for analysis. The authors' clinical and academic knowledge is likely to have influenced the analysis and thus the incorporation of deductive approach to some extent is acknowledged. Candidate themes were identified by arranging codes using a thematic map. A research psychologist coded (n = 12) transcripts. The first author and second coder discussed the codes, thematic map and candidate themes. This discussion lead to the merging of five subthemes. Following this, the first author met with the co-author to review the candidate and subthemes. No further changes were made.

Results

Participants

To contextualise the sample, a demographic summary of participants' characteristics, treatment history and symptom severity is presented in Table 1.

Table 1.

Participant characteristics, treatment history and symptom severity

Demographics		***N (%)***
Gender	Male	7 (25.9)
	Female	20 (74.1)
Ethnicity	Asian & Black African	1 (3.7)
	White	26 (96.3)
Education	GCSE or equivalent	2 (7.4)
	A level or equivalent	1 (3.7)
	Diploma	1 (3.7)
	Undergraduate degree	13 (48.1)
	Postgraduate degree	10 (37.0)
Employment	Unemployed (available for work)	1 (3.7)
	Sickness Benefits	5 (18.5)
	Student	1 (3.7)
	Employed part time	3 (11.1)
	Employed Full time	12 (44.4)
	Other (carer, retired)	5 (18.5)
		***M* (*SD*)**
Current Age		39.81 (11.86)
Symptom Severity	OCI	45.07 (31.13)
	PHQ-9	7.89 (8.62)
	GAD-7	7.74 (5.24)
	WSAS	15.81 (11.31)
History of OCD & treatment		***M (SD)* years**
Duration of OCD		27.26 (12.76)
Age of onset		12.56 (7.46)
Age significantly interfered with life		16.48 (7.63)
Age found out that problem was OCD		20.88 (9.43)
Age first diagnosed with OCD		29 (10.78)
Age first sought help		26.44 (11.30)
Age first offered treatment for OCD		29.81 (11.47)
		***Mdn* (Range)**
Number of past sets of therapy		3 (2-10)
Number of past sets of CBT		3 (3-10)
Experience of treatment formats		***N (%)***
Experience of weekly CBT only		17 (63)
Experience of Intensive CBT		10 (37)
		***M (SD)* months**
Longest period of being OCD - Free		6.04 (19.31)

GAD-7 = Generalised Anxiety Disorder; M = Mean; N = Number of participants; OCI = Obsessive Compulsive Inventory (Distress); PHQ-9 = Patient Health Questionnaire; SD = Standard deviation; WSAS = Work and Social Adjustment Scale.

Qualitative analysis

The analysis of participants' experiences of relapse identified four overarching themes: 1) *When stress is here, OCD is near*, 2) *Five slippery slopes to relapse* 3) *Factors related to therapy* and 4) *Sadness and fear: emotional responses to relapse*. See Appendix 1 for a thematic map depicting the overarching and subthemes.

Overarching theme 1: When stress is here, OCD is near.

This overarching theme captured participants' narratives around life stressors and the role they play in precipitating relapse. Three subthemes were identified: 1.1) *Responsibility milestones*, 1.2) *Too fraught to fight* and 1.3) *OCD thrives in isolation*. The first subtheme identified specific stressors that are either common occurrences in life or are aligned with the individual's specific OCD concerns. The second examined the cumulative effect of everyday stressors that undermine an individual's capacity to refrain from responding to intrusive thoughts. The third describes the impact of feeling socially isolated and lacking a support system and the link this has to relapse.

Subtheme 1.1: Responsibility milestones

Participants described universal human experiences that are all unpinned by an increase in responsibility, such as; leaving home to pursue education, a new job, getting married, becoming a parent and the death of a loved one. Participants identified that the stress that had accompanied these life events had contributed to or been responsible for relapse.

Some participants reported noticing the pattern of their OCD symptoms increasing and this coinciding with important life events.

> *Just before I was getting married, again that was a big event, I just found it slowly creeping and creeping in and becoming really, really big and then suddenly paralysing me (Sophia, x 4 weekly).*

> *I think it was a combination; I had started a new job […], and it was the responsibility. That's one thing I have noticed is that my OCD always flares up when responsibility is high. Starting university, a new job, having a baby (Rose, x 3 weekly).*

Some participants described the importance of being well for major life events, in combination with the additional responsibilities that would ensue, to cause a paradoxical effect and lead to the precipitation of OCD symptoms.

> *Mine was specific because I got pregnant again, so I felt under immense pressure to be well. Also, because I was pregnant that brought with it that maternal instinct that fuelled my OCD. Then I miscarried. I dropped down to being very, very unwell again (Janice, x 2 weekly, x 1 intensive).*

The occurrence of becoming a parent for the first time was reported to coincide with a relapse in OCD, for both men and women. Participants described that their OCD fears returned with a redirection of focus being on their child.

> *I've had it on and off since I was a child […] for the last eight years is that I've become a dad, […] My OCD focused on the idea that she would be either abducted or attacked or murdered or die as a result of an illness (Ethan, x 3 weekly).*

> *At first, I thought that it was just being anxious, being pregnant. It was my first child, having that responsibility. It wasn't until after I had him, I had to wash my bottles a hundred […] that's when I knew, OCD had come back (Keryn, x 3 weekly, x 1 intensive).*

Similarly, participants reported that whilst supporting a loved one during the process of dying they had either experienced a return of their symptoms or in the wake of their loved one passing OCD had reappeared.

> *We watched her die for like 14 months, and my OCD got really out of control […] but I thought, 'Once she dies, it will probably get a little better.' Actually, it exacerbated tenfold after she died (Alicia, x 8 weekly).*

> *In the process of losing mum and dad, they [OCD thoughts] weren't there at all, I was just so focused on them, but it was probably about a month after losing mum, so probably about three months after finishing treatment I started to really worry about my little boy dying (Joy, x 3 weekly).*

Participants described being able to attribute their relapse to a specific traumatic event that was aligned with the content of their previous OCD.

> *They [children] got an eye infection which is highly contagious and of course those words… you don't want to hear, having had contamination OCD. I think the first*

two weeks I knew I was really triggered by it, I was trying to stay really calm and wasn't doing anything particularly OCD, but I felt incredibly stressed out by it. But it relentlessly didn't go away. It [eye infection] stayed for 12 weeks […] I was traumatised, by the end of it I was absolutely wiping and washing everything. I didn't care if I had to bleach the whole house down, I just had to get rid of it (Harper, x 3 weekly, x 2 intensive).

Subtheme 1.2: Too fraught to fight

This subtheme captured participants' construction of the cumulative effect of general daily pressures and stressors that had corroded their resilience and undermined their ability to choose to respond to intrusive thoughts in a way that would help them to maintain their gains.

I find if I'm stressed in general my OCD symptoms get worse and I've been under a lot of stress […] at the moment I just haven't got much fight left to fight the OCD, so actually for a quiet life it was easier just to give in really (Natalie, x 4 weekly, x 2 intensive).

I still try and deal with it most of the time, but I feel that 10% of the time, I find if I'm rushed it would just be easier to give in to the feelings or putting on gloves to do something rather than sitting there dealing with it (Elaine, x 3 weekly).

Some participants reported that they didn't recognise stress as a contributing factor until after the relapse had occurred. They reported that on reflection they were able to see the connection with feeling less resilient in their approach to responding to intrusive thoughts during those times.

If I look at this year, I would say its stress related, dealing with general stress life, workwise and various other things, and I think I haven't always recognised when stress is causing my symptoms, almost not seeing the connection and the connection with hindsight is obvious, when I'm in the thick of it, I don't recognise it, buts that when I give in (Cooper, x 3 weekly).

Subtheme 1.3: OCD thrives in isolation

In this subtheme participants described the impact of symptoms reoccurring when feeling stressed within the context of a fragmented or absent support structure. Some participants reported that they had been unable to disclose their difficulties to significant others leaving them feeling unsupported and alone. For example, one participant reported,

"*I just needed some support. It was the fact that I was on my own and I had no one to talk to about it, I felt lonely and vulnerable and the fear got to me" (Gary, x 3 weekly).*

Some participants reported that their personal circumstances had changed which had caused additional stress due to needing to adapt to new environments, circumstances and to establish new support networks, but before this had been possible OCD had reoccurred.

> *I was thinking "how I am going to manage to do it?" no support and two young children. I don't have the support network here. Who do I contact? How do I get help? I was thinking I've left the UK, it's hard enough explaining what type of therapist you need in English, I've got no chance of anyone getting this here […] I think feeling so isolated didn't help (Harper, x 3 weekly, x 2 intensive).*

In addition, some participants described that it was the nature of the work they were undertaking that was socially isolating and thus led to relapse.

> *It was quite a stressful time cause I was writing my PhD thesis, I was alone a lot of the time, cause that's what you do when you're writing. So, there's lots of personal study time but no talking to anyone really and you just get more wrapped up in your own thoughts (Allie, x 3 weekly).*

Overarching theme 2: Five slippery slopes to relapse

This theme captured the different ways participants dealt with residual symptoms or triggers after successful CBT. Participants' intentions were to maintain their gains, but OCD was described as creeping back in.

Five subthemes were identified. In the first two subthemes 2.1) *Making deals with the devil: just small ones* and 2.2) *The underhanded swap: exposure for avoidance*; participants described being aware that their actions put their gains at risk. Conversely, the subthemes 2.3) *A stealth like return: infinitesimal to overgrown,* 2.4) *Don't rock the boat* and 2.5) *Beware OCD changes its clothes*; participants described the return of their symptoms as an inadvertent process, which they did not initially recognise as OCD.

Subtheme 2. 1: Making deals with the devil: just small ones.

A common theme in participants' reports was the intermittent use of what participants deemed to be 'small' rituals. Participants described being aware of the temptation to justify their use. For example, one participant said; "*You make all these little excuses and deals in your head to find ways to try and make everything okay" (Penny, x 6 weekly).* Another participant reported *"Some of it I realised, some of it I thought, "That's just sensible to do*

that and that's fine". I'd think "anybody else would be doing what you're doing" (Elaine, x 3 weekly).

Participants described that what started off as seemingly small, harmless rituals were the beginnings of the unravelling of their treatment gains.

> *I'll think, well, it's only a small thing, I'm not gonna do it, but then I'll think oh it's only a little thing, I'll just quickly do it, just one more. Oh, this ritual, it won't make a difference it's only a little one, it's a bit like that. But then it entices you into that cycle (Rose, x 3 weekly,).*

Some participants reported that although they were aware that the strategies, they were engaging in were not helpful, there was also a familiarity to them that was comforting. In difficult times some participants reported using their OCD as a way of coping.

> *I remember it feeling a bit kind of like, a, almost like a runaway train and a kind of like wanting to stop it but and also kind of a comfort and, a, even though it was distressing, it was a reassurance and it was familiar (Polly, x 4 weekly).*

Other participants described carrying out rituals as a way of being able to continue on with life in that moment, with a promise to rectify their undoing later.

> *Because I'd felt so paralysed by it, as soon as it started to go away, I was like, I can do things now, I can go out with my friends, I can wear what I like, enjoy things. I would think, I don't want to focus on doing treatment things just now, so I'll just keep going, do a quick ritual to get by (Sophia, x 4 weekly).*

Subtheme 2.2: The underhanded swap: from exposure to avoidance.

One prominent theme related to the way individuals had chosen to avoid situations that may trigger their OCD. Participants described that they were aware that they should be using exposure in such situations but described various reasons as to why it had been difficult for them to do so, such as, work or childcare commitments that had taken precedent.

> I *was about 80/90% better, and I think the problem was circumstances, I just didn't continue the momentum of going out and doing the exposure, it's just near impossible with two small children. Life got in the way and when I should have cracked on, I started avoiding (Harper, x 3 weekly, x 2 intensive).*

Some participants reported undertaking 'half exposure' in which they were attempting to confront their fears but would later undo their efforts by undertaking compulsions.

> *The reason I fell off was because I wasn't… I was living with the fear and exposing myself to the fear, but I was still doing the compulsions. That's the truth of it. I wasn't committing to things (Carlo x 3 weekly).*

A few participants acknowledged that they had completely stopped utilising exposure but had found benefit in avoiding all triggers. This was reported by some as useful until their lives had become very insular due to a relapse in their OCD.

> *I noticed I was avoiding the things that would make me become obsessive, I thought "I won't have to give in to this obsession if I just avoid this trigger". So then, I ended up getting rid of the things that were causing me anxiety. […] "I can cope with this by avoidance. I can cope with this by keeping out the way". […] until I couldn't (Gary, x 3 weekly).*

Subtheme 2.3: A stealth like return: Infinitesimal to overgrown.

In this subtheme participants reported that the resurgence of their OCD had been very subtle. They reported that it had returned in a way that had led them to either misinterpret their symptoms or for it to go undetected, only recognising OCD for what it was, when it had already embedded itself back into their life.

> *I think because it sort of, kind of, worms its way into different aspects of your life, and I think that for me, when it was creeping back in, it took me a little, to sort of think "oh hang on a minute I know what's happening here", but by then it sort of had its claws in (Karina, x 3 weekly).*

Some participants described the process by which their intrusive thoughts had crept back in and found a space in their minds by attaching themselves to thoughts they perceived were unrelated to OCD.

> *It's subtle. It's always subtle […] we were going to move, I started thinking about people coming in to do the packing, […] "I wouldn't want them touching […] It sort of creeps in, intermingled with a thought you think, "well that definitely isn't OCD", but there's an element of OCD attaching itself nicely, and so it creeps in like that. Initially that's the level it was staying at, just creeping around in my head a lot, but I*

wasn't necessarily doing any compulsions, but all the thoughts were triggering away nicely (Tina, x 6 weekly, x 1 intensive).

In addition, participants described that because they had overcome their OCD, they had regained a substantial amount of time that had previously been consumed by rituals. Some participants described wondering if this has been part of the reason, they had not recognised it.

I just had a lot more time and energy. I think then what happened, it wasn't anything specific, the OCD just grew infinitesimally. You didn't notice it growing, in terms of time. Nothing was triggering me specifically. It was just a little bit longer in the shower, and a little bit more handwashing (Sharon, x2 weekly, x 1 intensive).

Subtheme 2.4: Don't rock the boat.

In this subtheme participants' narratives emphasised the joy of reclaiming their lives from OCD. However, consequently they were reluctant to do anything that may potentially jeopardise their wellness. This meant they did not continue to tackle their remaining symptoms in an attempt to maintain their new equilibrium.

My symptoms lessened to the point where it wasn't a big interference in my life, and I was not wanting to rock the boat. It was that last 10% or 20% of problem that I just…I was enjoying having my life back and the effort and the drain and the anxiety of doing ERP for that last 20% didn't seem worth it at the time (Cooper, x 3 weekly).

However, participants did recognise that in hindsight, perhaps what had been needed was to be encouraged to go further and to conquer the remaining 10-20%, ensuring there was no room for their gains to unravel.

I still had little bit left, but I wasn't too worried about them because life was just so much unimaginably better. They weren't distressing me, and they weren't taking up much time. I don't know whether I would have been willing to do it, but it would have been helpful to have it suggested, in a sense within that three months, while I was still elated, that I needed to go further. It's chicken and egg, isn't it, because if you are feeling so much better, and you are very frightened of doing these anti-obsessional tasks; why would you want to do that (Sharon, x2 weekly, x 1 intensive).

Subtheme 2.5: Beware OCD changes its clothes.

In this final subtheme participants constructed OCD as re-emerging in an unrecognisable form. This meant the content of the individuals OCD had changed from what they had previously been concerned about and experienced. For examples, one participant said; "*I mean, I knew that it was OCD with the door […] but I had no idea that this other stuff was, I thought I was a monster" (Genevieve, x 2 weekly, 1 intensive).* Participants described that due to the different content it was difficult to discern if it their new concerns were in fact OCD*. "I think the hardest thing is when they pop up in different disguises because your head can make you feel like, oh this is different" (Carlo x 3 weekly).*

Some participants described that due to the change in how OCD presented, the strategies that they had previously used successfully, were no longer applicable.

> *I felt like I was trapped, that there was no way out. This is the thing, the strategies that I had and that I had used for so many years, I just couldn't apply. Because when we were talking about say the lock being broken, someone breaking in, % of blame […] But it changed to my son, no one was responsible apart from me (Allie, x 3 weekly).*

However, interestingly participants who had further overcome a change in the presentation of their OCD described that regardless of the presentation the same core skills were required to treat all OCD.

> *The other thing that happened which I would say was a big factor is, in the OCD morphed, it changed how it appeared. […] it came back in a completely different form. This is the wonder of it that I've found, it's the same however the OCD comes along, whatever costume it's got on, it's still the same way to treat it (Hunter, x 2 weekly, x 1 intensive).*

Overarching theme 3: Factors related to Therapy

This overarching theme captured factors relevant to three aspects of therapy; 1) content of what was addressed in therapy, 2) endings of therapy and 3) participants' perceptions of what should be delivered post therapy. Three subthemes were identified; 3.1) *I didn't tell you what I needed to: Still mad, bad or dangerous*, 3.2) *Better, but not 100%* and 3.3) *The complete therapy package, including breakdown cover.*

Subtheme 3.1: I didn't tell you what I needed to: Still bad, mad or dangerous.

In this subtheme participants reported that they had felt too ashamed to disclose the intrusive thoughts that they found most distressing in therapy, which were generally sexual in content. In some cases, the therapist had not asked about the presence of such thoughts or

if they had been raised, they had not been addressed further in therapy. Whilst these participants reported making gains, they were likely to have been superficial as participants described leaving therapy with the belief that these thoughts meant they were still possibly 'mad, bad or dangerous'. It is thus understandable that they described their gains being lost relatively quickly.

> *I felt fairly confident at the end of this lot of therapy, that I had enough tools to go away and manage my OCD. But I still hadn't dealt with some of the thoughts that I was having. I hadn't felt able, and she hadn't asked. Not very long after, something specific happened to trigger thoughts about whether I was an immoral person and it all started to unravel again (Ethan, x 3 weekly).*

> *The things that we didn't talk about was that I worried I was going to become a paedophile. So it was that really. I mentioned it in one session with her, and she talked through it with me, but we never went back to it. To begin with I was able to deal with it, but I reverted back […] I couldn't take away that trigger, because he [son] was always there (Gary, x 3 weekly).*

Subtheme 3.2: Better, but not 100%

A prominent thread across the data was that although participants had made good therapeutic gains, which they were pleased with, at completion of their therapy, they were not in remission. There was still 10-20% of their symptoms remaining. This was perceived as a key factor that led to relapse.

> *It's like a scab, that has almost healed but not completely, eventually you just start picking at it again, and it gets infected again or it's like getting rid of 90% of the tumour and then eventually it grows back. Each time, I've been so much better but actually part of it is still not being totally tackled (Penny, x 6 weekly).*

> *I think probably the core of the problem and every time that I had it [CBT], because it's been a limited number of session, but I felt like I've always left a little bit there and not totally got rid of it, not totally rooted out the problem (Sophia, x 4 weekly).*

Some participants described that therapy had ended due to pre-determined factors such as quota of sessions or the therapist's availability, rather than their individual progress. Thus, participants believed further sessions would have helped them to consolidate their gains and made progress towards remission.

I had a brilliant therapist, and I made a lot of progress, but then she went on maternity leave, so the therapy ended. We did quite a good ending, however I went from having quite a lot of support, to none. I started to feel out of control with the OCD symptoms not too long after (Allie, x 3 weekly).

We did very well, and we did some specific work and so that was fine […] we didn't manage to get to the top of the hierarchy, but then it was, 'We've had our session'. I was then left a bit high and dry (Gavin, x 3 weekly).

Some participants raised the inequities between the quality of care and follow-up that are provided for physical health problems, but not mental health problems. Drawing on the idea that treatment would be provided until remission for a physical health problem without question.

The NICE guidelines effectively mean absolutely nothing because they're guidelines to be followed if you can, but if you can't it's not really an issue […] I had the 20 [sessions], I'd made progress, but I wasn't where I wanted to be, but I'd improved on some things. I had to go back on a waiting list and that was nearly a year before I then got back to see somebody […] I'd unravelled in that time […] now we're on a point, equal parity, where it was physical and mental health treatment […] if I had a broken leg, I wouldn't be left would I? I know it sounds so trite, but you'd be back down the doctors saying look I've still got this… It's like no, you've had your lot, whether we've fixed you or not, you're on your own (Leticia, x 3 weekly).

Subtheme 3.3: The complete therapy package, including breakdown cover.

Participants placed emphasis on the aspects of therapy they perceived would have helped prevent relapse, focusing on relapse prevention and the provision of booster or follow-up sessions. Participants described that a more in-depth and specific relapse prevention plan that is idiosyncratic to the individual was required. Participants described that it would be helpful if the therapist spent time thinking with them in session about their possible vulnerabilities and what strategies they could potentially use or how they might need to be adapted.

She [therapist] would say things like "you can use these tools for any compulsion that crops up", but I guess that we never looked at what my potential traps might be (Evie, x 4 weekly).

It was covered that if it comes back, these are the strategies, you've got the strategies now, and you can use them. But there was nothing to say, just as a warning if it does come back, it might come back different and you might have to adapt the strategies. (Allie, x 3 weekly).

I think you need to build into your therapy model an expectation of relapse and a support structure when it happens (Gavin, x 3 weekly).

Participants expressed their desire for booster sessions and the unhelpful cycle that was occurring in their absence. This entailed being denied access to further treatment until a full relapse had occurred for which a re-referral could be made, and a new episode of care opened. Understandably participants expressed wanting to circumvent the occurrence of relapse.

I described it as what I wanted was "roadside breakdown provision" just to get me going again if I needed it, I didn't want the whole service (Cooper, x 3 weekly).

Things were starting to crop up, and I did actually go back and try and have a bit more therapy locally […] then it all went a bit haywire, because the next person did another assessment and said, 'Your OCD isn't severe enough to merit us giving you therapy.' (Carlo x 3 weekly).

Psychologist said there might be top-up sessions but didn't make it clear that twenty was the absolute limit. Then when I said, 'Can I have some top-up sessions?' she said 'No', it would have to be a re-referral pathway back into the service (Leticia, x 3 weekly).

Participants' narratives around follow-up not being offered and the extremes participants constructed as being necessary in order to access follow-up were described. Across the sample, all participants reported that follow-up should be offered as a key tool in preventing further relapse.

The trouble is the NICE guidelines says you should get follow-up and I think that would have helped […] Wish there'd been a resource that you could go back to, so you can catch it if you're starting to relapse, rather than having to go through it all (Gary, x 3 weekly).

It almost seems that you have to get really, really bad again before you can get any more treatment. Most recently I tried to access treatment again I went to [X] Hospital and basically it was the most horrible experience. I went into a room and there were

10 people […] they were all saying you're not bad enough. We've got people who are really, really bad in here (Sophia, x 4 weekly).

One participant in the sample had received follow-up. This participant described the severity of their condition that had led to the provision of follow-up. This participant highlighted the complexities of comorbidities that can be associated with OCD and was keen to speak out against the stigma linked with needing to access further support or services.

I only got support from the community mental health team because I had tried to commit suicide twice and I must have reached some kind of quota, where the doors open and you are suddenly allowed more things, like follow-up. I don't think that it should be "well, you know, you have to go and try and commit suicide a few times and then we'll see you". I've never spoken to an OCD sufferer who at some point has not seriously considered or attempted suicide. That is how serious this problem is, […] there's often depression going on, all kinds of stuff that's co-morbid, OCD is enough, it's hell enough to make you really poorly, so I think there is a lot to be said, for being told that you're too reliant on services. But I [expletive] worked so hard to get better. I put 100% into getting better. That doesn't mean that I should have to now go alone if I do need more support down the track, it doesn't mean that by having services there that I am suddenly putting in less effort (Penny, x 6 weekly).

Overarching theme 4: Sadness and fear: emotional responses to relapse

This theme captured participants' emotional responses to the return of their OCD symptoms as well as the experience of comorbid depression. Three subthemes were identified: 4.1) *The ominous terror of the return*, 4.2) *Depression and OCD: A symbiotic relationship?* and 4.3) *The perfect storm: low mood, low confidence and self-doubt.*

Subtheme 4.1: The ominous terror of the return.

Participants were asked how they felt when they first noticed signs of their OCD symptoms returning. Participants constructed wellness as a state that was under threat from OCD and that could be seriously diminished by its return. The perceived power of OCD was evident in participants' descriptions and, as such, the first signs of symptoms returning were met with strong emotional reactions. A spectrum of emotional responses was described from feelings of vulnerability and shame through to desperation and defeat.

Some participants reported experiencing full remission and sustaining this for an extended number of years. Thus, the return of symptoms was met with shock. It was as if

the participant had thought that they had escaped and left OCD behind, but then it had reappeared, hence leaving them with a sense of vulnerability.

> *It made me realise that if you've had OCD and you've responded extremely well […] there's always a part of you that's going to be vulnerable […]. That was a lesson for me, not to be so up myself if I was ever talking to people saying, "Oh you can always get over it, it's what I had, and you can do it" (Semone, x 3 weekly).*

Other participants described a strong sense of shame associated with the idea that a lapse was synonymous with failure.

> *Not wanting to admit that it was back again. I knew how difficult it had been for everyone and how upset it made them [family], but actually not wanting to say, "oh I've failed and I'm finding this difficult" because, as soon as I do, I see them starting to panic and being like, "oh no, it's all coming back and it's all going to get bad again" (Amber, x 2 weekly, x 1 intensive).*

The most common response were feelings of frustration, anger and being scared, which seemed to be underpinned by a lack of control. The enormous amount of energy required to overcome OCD was conveyed along with concern that symptoms would escalate quickly. "*I felt overwhelmed and concerned whether I'd have the energy to fight it again" (Max, 3 x weekly, 1 x intensive).*

> *[…] partly frustration. It's that kind of exasperation and anger that the OCD thought is there. That you're then starting to respond to it again. I suppose that's linked to a disappointment, definitely a huge amount of fear of it, of it going downhill again massively (Harper, x 3 weekly, x 2 intensive).*

> *It is just devastating, and it gets scary too, because you are thinking, "Am I going to go back to ground zero and have to start all over again" […] "Am I going to go back to having no life whatsoever?" "Am I ever going to live a normal life?" (Alicia, x 8 weekly).*

The frustration of the return of symptoms also led some participants to describe dealing with this via outbursts of self-harm.

> *I'd been out for dinner with my boyfriend and we'd got home, and I got stuck, I couldn't get myself out of the bathroom [due to OCD], I was irate with myself, I just start hitting my hand against the wall to try and release frustration (Tina, x 6 weekly, x 1 intensive).*

Other participants reported a sense of defeat and thoughts of suicide on the return of symptoms. Their narratives included a sense that OCD was relentless and that it was always looming, and perhaps successful treatment had been the anomaly.

> *If anything, it just confirmed what I'd always felt; that OCD was just so hard to shift. I'd had it all those decades before having CBT, and since I'd tried umpteen times to reduce it and stop it. In one sense it was more the huge change that had happened after the intensive therapy that was the exception. Then when it started to come back it was more, "well that's what OCD does" (Sharon, x 2 weekly, x 1 intensive).*

> *I felt as if a part of me wanted to die, I think I frightened myself so much, because I was starting to feel quite suicidal, I never tried, but I was very aware that that was an option for me if this [OCD] was going to get so bad again (Penny, x 6 weekly).*

Subtheme 4.2: Depression and OCD: A symbiotic relationship?

Co-occurrence of depression was a key aspect that featured strongly in participant reports. Participants were divided in their experience of whether depression had led to OCD or vice versa, or if depression occurred for a separate reason. Participants constructed the experience of co-morbid depression in four different ways.

Firstly, participants described gaining insight into the 'collateral damage' that OCD had caused in their life. *"Depression comes in, now that I can see how much I've lost, what they say about the collateral damage, stands, doesn't it" (Penny, x 6 weekly).* Others described feeling depressed due to having missed opportunities in life due to their OCD. "*Not being able to have children anymore has big links with the original manifestations of my OCD […] now it links with the grief about not having children because of my OCD […] it has contributed to depression" (Genevieve, x 2 weekly, 1 intensive).*

Secondly, some participants described being unable to identify a clear cause for becoming depressed. However, participants' descriptions were underscored by a change in identity that had unexpectedly occurred as a result of recovery.

> *I was 80% better […] but I became depressed. I became more tired and whilst I was able to work fine, […] I wasn't ok at home and then became concerned about things that might be contaminated […] So, it began again (Max, x 3 weekly, x 1 intensive).*

Thirdly, some participants described their OCD as having been primary and depression secondary, however in the absence of OCD depression had become the focus and OCD symptoms had crept in and were fluctuating according to mood.

I became preoccupied with how down I was feeling. I was feeling more down over a long period than I had ever felt […] so, it was the OCD following the depression; in the past it had been the OCD [as] the main problem, and then the depression following on from that. It was gradual as well, so in that sense it was similar, handwashing was increasing, showering was increasing. As I was feeling more down the symptoms increased (Sharon, x 2 weekly, x 1 intensive).

Finally, participants described the habitual nature of OCD being linked to low mood, and how intertwined the two difficulties could be.

I think it was a combination of things which led to me being very low and depressed and then the OCD came back almost like a habit associated with me feeling down (Natalie, x 4 weekly, x 2 intensive).

There's depression tied in there and I never know where one starts and the other ends to be honest, it is quite inexact […] (Hunter, x 2 weekly, x 1 intensive).

Subtheme 4.3: The perfect storm: low mood, low confidence and self-doubt.

This subtheme depicts the unravelling that occurs, which can lead to relapse when an individual is feeling low in mood and confidence and they begin to doubt themselves and their own thoughts. Participants described being unsure as to whether their inner voice was OCD or not, they described that it was difficult to tell and thus the process of trying to work this out continued and inevitably led back to OCD.

It's that inner voice that's talking to you that doubt casting doubt, you hit a bump, you lose your confidence. Suddenly you think, "I can't do this on my own." The fear grips, which is OCD, it says, "You can't do this on your own." (Harper, x 3 weekly, x 2 intensive).

All of the times that I've had relapses over the last year or so, it's been the, 'What if this isn't OCD?' voice (Evie, x 4 weekly).

Feeling powerless against OCD was a common theme within the data. Participants often described OCD as if it had a mind of its own and was lurking in the background waiting for the opportune time to reappear.

The OCD is just so strong when it comes on sometimes, it was like, "no, you can't be better", "there's room for OCD now" and it sort of pounced on me […] It found the weakness at that point and preyed on me again. It thought, "right, she's low, I can get

in", I had a lot of ruminations over […] I didn't have any confidence or anything in me to dismiss that thought it just took over me, so I believed OCD over myself, I came to a grinding halt again (Rose, x 3 weekly,).

Discussion

The main aim of this study was to provide an in-depth examination of the factors participants perceived led to relapse after successful CBT. This was done from the perspective of the specific sample used here, which was OCD participants who had experienced multiple CBT failures. Participants had also undertaken a course of CBT in either an intensive or weekly format that had been successful, although following this they experienced a relapse. The main factors that participants identified as being linked to relapse fell under three overarching themes. Participants linked specific life events and stressors to the occurrence of relapse. The cumulative effect of everyday stressors on participants' capacity to respond to lapses in symptoms was key (Theme 1: *When stress is here, OCD is near*). Participants described a variety of behavioural and thinking patterns that inadvertently led to lapses (Theme 2: *Five slippery slopes to relapse*). The content of therapy in terms of relapse prevention and the addition of booster or follow-up sessions were deemed important by participants for preventing relapse (Theme 3: *Factors related to Therapy*). A further theme was identified in which participants described fearing the incapacitating return of OCD and the uncertainty of recovery and the impact that this would have on their loved ones. This theme also explored the comorbidity of depression and the effect of feeling socially isolated (Theme 4: *Sadness and fear: emotional responses to relapse*). Three factors specific to the therapeutic process or content of therapy were identified and discussed in theme 3 and will be further examined here. There were no clear differences in the reports of participants who had recovered from intensive as opposed to weekly CBT, hence why differences were not discussed in the analysis.

In themes 1 (*When stress is here, OCD is near)* and 2 *(Five slippery slopes to relapse),* participants described stressors, thinking patterns and behaviours that had accumulated and led to relapse. In a large study of therapists' treatment of OCD, 52% of therapists reported that more than symptom reduction was necessary in the treatment for OCD (Jacobson et al., 2016). That study had not sought the specifics, however the authors postulated that the issues of concern may be; quality of life, level of functional impairment,

stress levels, interpersonal relationships and support, and the current study identified similar factors. Our findings suggest that focus should be given to supporting the individual to consider how they will reclaim their life in the absence of OCD. As OCD occurs generally before the age of 18 years, and the duration of untreated illness is on average 10 years (Fienberg et al., 2019) by the time an individual receives adequate treatment they have spent a significant proportion of their life and their time preoccupied by OCD. It is therefore reasonable to expect that individuals will need support adapting to their 'OCD-free life' and the challenging changes in social and personal identity which are likely to be involved.

The role of the therapist is to encourage their patients to 'rock the boat', capsize and overcome the last of their symptoms and swim to the OCD-free shore. However, our findings suggest that what is fundamental to the success of recovery, is that on arrival to the OCD-free shore, there is an OCD-free, but full life. Filling the void of time that is likely to be created by the absence of OCD, should constitute medium and long-term goals in therapy, to ensure the patient is working on this from the outset of therapy. Our data suggest that other areas that may need to be considered for this population of service users is the collateral damage that has been caused by OCD and the consequent effect on self-esteem and confidence (e.g. no longer being able to have children due to OCD). Work examining the application of compassion focused therapy for OCD has been implemented clinically but is yet to be tested experimentally (Bream, Challacombe, Palmer, & Salkovskis, 2017). Future research should consider if this may be an efficacious adjunct to CBT for OCD or potentially a part of a relapse prevention programme for individuals who have experienced multiple treatment failures.

The third theme, *Factors related to therapy*, focused predominately on two areas: 1) recovery, and 2) follow-up. As established, the evidence-base for prevention of relapse is sparse. However, what has been shown to predict relapse is non-optimal response. This raises two potential issues, firstly whether therapy content is inadequate for this particular group of service users and secondly the issue of inadequate dose. In response to the first issue, participants identified not fully disclosing their most distressing intrusive thoughts, thus such thoughts were not tackled in therapy. The presence of sexual and or violent obsessions has been identified as a factor for delayed help seeking (Glazier, Wetterneck, Singh, & Williams, 2015). There is a wide literature around stigma and disclosure of such obsession, with the focus on normalising such obsession and the importance of addressing these in therapy (Cathey & Wetterneck, 2013). More broadly, research from Craske and colleagues (2008, 2013) have suggested a range of strategies for enhancing CBT drawing on learning and memory models. Abramowitz and Arch (2014) provide an excellent summary

of how these techniques may be applied within the context of OCD. A case study of a patient who had responded relatively well to CBT although relapses after 14 sessions, is used to illustrate how the techniques may be applied. This avenue of research offers promising directions for further investigation of ways in which CBT can be enhanced.

In the current study, participants predominantly reported reasons for relapse aligned to inadequate "dose" of CBT. In these cases, participants reported a vicious cycle. The fault appears to lie within the health care system, which dictates a limited number of sessions rather than treatment to the point of problem resolution. It would be appropriate and likely cost effective if the system permitted the provision of booster sessions or follow-up. The aim of booster sessions is to circumvent the requirement of a new episode of care by providing the support needed for the individual to retain their gains. In RCTs participants are often offered booster sessions as a part of a treatment trial. For example, Foa et al. (2005) provided two home visits and eight consolidation sessions of 45 minutes each on a weekly basis post intensive CBT. More recently, Challacombe et al. (2017) offered participants three booster sessions at monthly intervals post treatment. In addition, the participants in this study would meet the criteria utilised by the NICE guidance in Step 6, which recommends follow-up for one year, once the patient is in remission (NICE, 2005). This approach would significantly benefit both the sufferer and service in the longer term and has implications for service provision.

In the final theme of the current study; 4 (*Sadness and fear: emotional responses to relapse*) participants did not explicitly identify their fears of relapse as being linked to relapse. However, their descriptions of their emotional responses to relapse are consistent with literature suggesting that the experience of previous episodes of poor health can lead to continuous worry or preoccupation about relapse, often known as "fear of illness recurrence" (FIR) (Ietsugu et al., 2015; Lee-Jones, Humphris, Dixon, & Bebbington Hatcher, 1997). This worry can in itself result in distress and impairment, impacting on selective attention, producing a kindling or vicious circle effect (Cassin & Rector, 2012). FIR has been found to be a predictor of actual relapse, with those higher in fear experiencing relapse sooner than those who exhibit less fear of relapse (Gumley et al., 2015). FIR was originally highlighted in physical health problems i.e. remission from cancer (Bellizzi, Latini, Cowan, DuChane, & Carroll, 2008; Crist & Grunfeld, 2013; Koch, Jansen, Brenner, & Arndt, 2013) and stroke (Townend, Tinson, Kwan, & Sharpe, 2006).

Gumley et al. (2010) has examined FIR in individuals with psychosis, finding that those who relapsed scored more highly on negative beliefs about their illness and had lower

self-esteem in comparison to those who had not relapsed. Negative beliefs were linked to a lack of control and appraisals of entrapment (Gumley et al., 2015). The findings of the current study are consistent with the findings of Gumley et al. (2015) who also reported that those experiencing FIR tend to view relapse as a catastrophic event, consequently avoiding thoughts, behaviours and emotions related to the experience of illness (Gumley et al., 2010). The current study found that participants reported feeling defeated and that suicide felt like an option opposed to relapse. The term 'mental defeat' refers to the perception of oneself as having 'failed' or feeling dehumanised and lacking agency because of a mental health problem or traumatic events, and is relevant here (Gilbert & Allan, 1998). Some participants' reports were consistent with the phenomena of mental defeat. Research in this area has investigated links between defeat, entrapment and psychopathology in the domains of depression, suicidality, PTSD and other anxiety disorders, but not specifically OCD (Taylor, Gooding, Wood, & Tarrier, 2011). Research is also yet to focus on FIR specifically in OCD, however the findings of the current study suggest that this should be further investigated.

The findings of theme 4 also highlighted co-morbidity between OCD and depression, which has been well established as a reason for treatment non-response in OCD. (Abramowitz & Foa, 2000). However, the role of this comorbidity post-treatment has been less well examined. The findings of this study suggest that some participants struggle significantly with depression following successful treatment. Further research efforts should investigate this in a larger sample with a view to consider how booster sessions can support individuals who may be vulnerable to this comorbidity.

Similar to OCD, depression has high rates of relapse (50-80%) (Shallcross et al., 2015). The past two decades have seen substantial research efforts focused on developing a relapse prevention programme for depression. Such efforts have culminated in the development of Mindfulness Based Cognitive Therapy (MBCT). This intervention is delivered in a group format over eight weeks and has efficacy for individuals with > 3 previous episodes of depression (Ma & Teasdale, 2004). Despite similar rates of relapse for OCD, there has been a dearth of research from a psychological perspective. At present, the main body of relapse prevention research is focused on pharmacological intervention, with less than satisfactory outcomes (Catapano et al., 2006; Fineberg, Tonnoir, Lemming, & Stein, 2007; Hollander et al., 2003; Maina, Albert, & Bogetto, 2001; Romano, Goodman, Tamura, Gonzales, & Group, 2001). The finding from this study and other research (Millar et al., in prep) suggest that a staggered finish to therapy or booster sessions delivered once a month for a period of six to twelve months is desired by this group of service users. Along the lines of this suggestion, but within the field of Panic Disorder (PD), is the trial of a

maintenance CBT (M-CBT) program. This program aimed at maintaining acute treatment gains and preventing relapse. PD patients who responded to treatment were randomised to receive nine monthly session of M-CBT or assessment only. At 12-month follow-up the M-CBT group had significantly lower relapse rates and reduced functional impairment in comparison to controls (White et al., 2013). These findings are promising and investigating the transferability of such a programme to an OCD population is needed.

Future research directions

Findings from the current study provide a starting point for developing a maintenance/ relapse prevention program for OCD. For instance, the focus of themes 1 and 2 (i.e. responding and managing stressors and lapses) are likely to constitute meaningful sessions within a maintenance CBT programme for OCD. FIR is also a strong candidate for further work in this area. Further research is required to determine the generalisability and predictive validity of the identified factors from this study within a larger sample of individuals who have experienced OCD relapse. It is envisaged that these findings could then be utilised to develop a relapse prevention program that is made available to individuals once they are in remission from OCD, which accommodates the key aspects that are relevant to OCD relapse.

Clinical Implications

The findings of the current study have clinical implications for current practice. Kuyken and colleagues (2009) utilise case formulation throughout the therapy process, including its use to inform the relapse prevention plan. The findings of this study suggest that utilising a formulation to tailor an idiosyncratic relapse prevention plan that considers potential stressors and ways to deal with lapses would be useful. Our findings suggest that therapy and the relapse prevention plan should consider;

- A plan for what to do when aspects of OCD creep back in
- The possibility of OCD changing its clothes particularly at times of elevated stress
- What the very early warning signs may be for the individual
- The support systems the individual has in place or what they might need to do to build these
- Strategies for dealing with low mood and depression
- Discussion of ways of identifying and counteracting FIR
- How the individual will use their OCD free time

Thought should also be given to how the participant will store and access their relapse prevention plan. Creative solutions including the use of the patient's phone or video recording could be explored.

The results of this study also provide a reminder for therapists to ensure the normalising of intrusive thoughts that are sexual in nature, to aid in patient disclosure to ensure that these intrusive thoughts can be the focus of intervention.

Limitations

The findings from this study should be considered within the context of their limitations. This study had very specific recruitment criteria. Sampling was purposive, we recruited participants who had experienced; a) $\geq$ 2 unsuccessful courses of CBT, b) a successful course of CBT, which was followed by c) a relapse. To recruit this sample, snowballing techniques were utilised, thus a random sample of participants with OCD was not recruited. Nonetheless, appropriate measures were taken to ensure a clinical population with a confirmed diagnosis of OCD were recruited.

This study was cross-sectional in design therefore it did not allow for change criteria to be applied. Participants retrospectively reported the severity of their symptoms, the extent of change achieved, and the length of time gains were sustained. This is subject to memory biases in recall. A study which is designed to capture participants' level of severity in real time through a standardised measure i.e. OCI and validated with therapist assessment e.g. Y-BOCS pre-treatment and post treatment and at intervals after treatment, would provide more accurate representation of the participants level of symptoms, response, remission or recovery and indicate when relapse begins to occur. Qualitative interviews at these time points would be ideal. Improving Access to Psychological Therapies Programme (IAPT) may provide such opportunities.

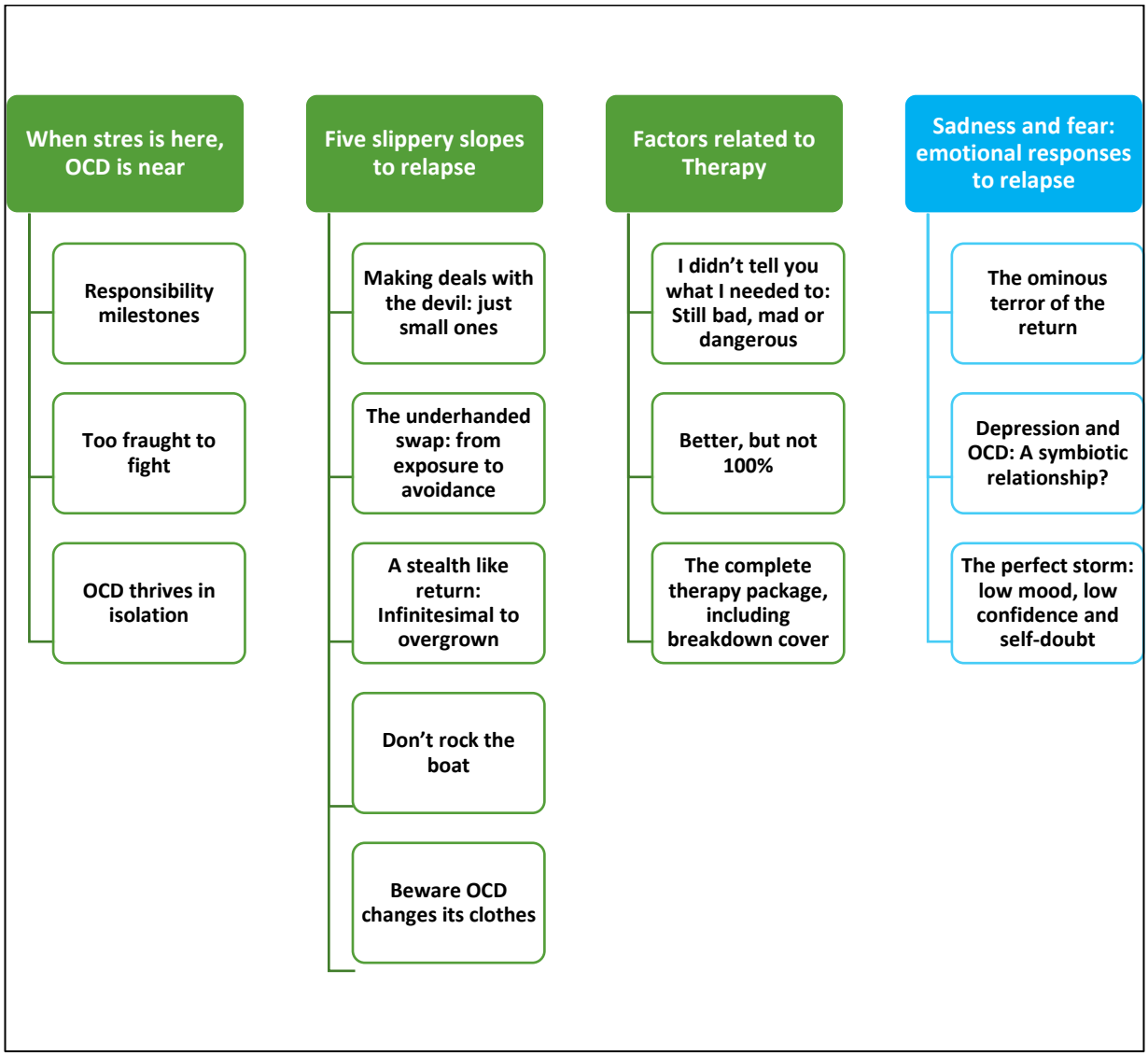
This study aimed to explore if there was a difference in the experience of individuals who had recovered from OCD after an intensive version of therapy in comparison to those who had recovered from weekly CBT. There were only a small number of participants who had completed intensive treatment and thus the comparison was limited. There were difficulties in recruiting individuals who had recovered from an intensive version of CBT and then experienced a relapse. This may be due to the relative difficulty in seeking an intensive treatment or perhaps the effectiveness of this format for which efficacy is yet to be determined (Millar, Bauer, Halligan, Purnell, & Salkovskis, in prep). Further research is required with a larger, more comparable sample. Participants were not recruited specifically from a specialist clinic, which is most likely to administer intensive format CBT.

Recruitment from such services may be a useful strategy for future research aiming to make comparisons for this format.

Conclusion

This study investigated relapse from the perspective of the service user. Life stressors, as well as specific cognitive and behavioural traps were identified by participants as leading to relapse. These are aspects that can be picked up upon in therapy and addressed in relapse prevention planning. In addition, participants emphasised the importance of booster or follow-up sessions as an essential part of relapse prevention. This is important and has implications for the NICE guidelines and service provision. At present follow-up is only addressed within the NICE guidance at the final step of care recommendations. The participants in this study would meet the inclusion criteria for this step of care, yet participants reported not being offered follow-up. Future research efforts should be focused on developing a relapse prevention programme for OCD.

Appendix 1: Thematic map depicting the identified overarching and subthemes.



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CHAPTER 11: DISCUSSION

Overview

This thesis centred on the problems associated with the limits of conventional CBT for OCD and the treatment option of intensive CBT as a leading solution to such problems. In a large part the questions posed paradoxically arise from the success of CBT, which then raises questions about how this success can be extended and sustained, for example, by considering changing the mode in which CBT is delivered rather than simply adhering to traditional ways of conducting therapy. To address the issues associated with this, this thesis had the following aims;

1) To explore the current understanding of OCD as a disorder including its impact on the sufferer and the evolution of treatment.
2) To gain an understanding of and critically evaluate the treatments being recommended and or used for OCD.
3) To systematically evaluate the evidence base on which the NICE recommendation of an intensive treatment is based.
4) To gain an in-depth understanding of the experience of multiple treatment failures and the reasons for this from the perspective of the service user.
5) To examine the treatment option of CBT delivered in an intensive format from the perspective of the service user and therapist.
6) To examine OCD service users' preferences for the treatment format of CBT.
7) To gain an in-depth understanding of the experience of relapse after successful intensive or standard CBT.

To achieve these aims Chapter 2, 3 and 4 critically evaluated the literature regarding the impact of OCD and the development of theory and treatment, with a specific focus on treatment delivery in an intensive format. Specific issues were identified, which further informed the studies that were reported in Chapters 6, 7, 8, 9 and 10. The current chapter firstly summarises the key findings from each chapter in relation to the corresponding aims. The overarching findings are then synthesised with the clinical implications of the research described in this synthesis. Two key themes are identified that span across the studies are used to orient the synthesis. Limitations of the current findings are discussed and future directions for research are proposed.

Summary of key findings

As demonstrated in Chapters 2 and 3 there has been a remarkable transformation of the prospects for effective psychological treatments for OCD. The success of these treatments has been driven by a combination of theory, both generally regarding anxiety and specifically related to OCD, as well as developments in the general understanding and effectiveness of cognitive behavioural treatments. However, this remarkable progress has slowed to what amounts to a steady state, with a significant proportion of individual's still failing to recover following CBT, alongside those who do recover although subsequently relapse. Those who do not respond to treatment often remain significantly impaired by their symptoms and may seek treatments without an established evidence base that are accompanied by significant risks. One possible reason for this "levelling out" of treatment progression relates to the delivery of therapy, which has been constrained by precedent, historical and service level factors, leading to a neglect of alternative format treatment options such as intensive treatment. The research in the following chapters addressed the identified gaps by investigating both treatment non-response and the perceptions and preferences related to the format of intensive CBT. This is followed by an examination of relapse, which was one of the key concerns identified regarding intensive CBT.

Chapter 4: Study 1 comprised a systematic review of the studies that have examined the delivery of CBT for OCD in an intensive format. This review revealed that there are only a small number of well-controlled studies of intensive CBT. Those that have been conducted are heterogeneous in their comparators, making a meta-analysis of findings unfeasible. None of the included studies examined the efficacy and acceptability of intensive CBT specifically for patients who have not previously responded to treatment. In addition, no study included a direct comparison of standard and intensive CBT for OCD. Therefore, while the individual studies included in the systematic review indicated that intensive CBT may be acceptable and effective, there is very little empirical support for the NICE recommendation that intensive CBT should be offered to those with multiple previous CBT failures. In addition, there is little evidence to support the potential added value of intensive CBT as compared to weekly CBT delivery format.

Following this, Chapter 6: Study 2 involved a detailed, qualitative examination of the reasons given for treatment non-response by individuals who have not fully benefited from CBT for OCD. An equivalent group of Panic Disorder (PD) patients was included to provide a comparison group to allow for an examination of factors that may apply across

disorders or are specific to OCD. This study indeed found both common and specific factors, with common factors pertaining mainly to the therapeutic interaction and relationship. Specific to OCD were external factors that impacted the individual's functioning, as well as the practical barrier of not being offered a sufficient "dose" of therapy.

In Chapter 7: Study 3 intensive CBT as an alternative format was investigated from the perspective of service users with OCD who had experienced multiple treatment failures. Intensive CBT was generally found to be acceptable and regarded as an effective option with longer sessions perceived as providing a solution to problems identified in Study 2 (e.g., lack of in-session ERP). However, some participants noted important reservations specific to the intensive format. Participants expressed concern about the intensity of and the emotional impact of the intervention and the possibility of relapse particularly in the absence of sufficient follow-up.

In order to gain a rounded examination of intensive treatment, therapists views were investigated in Chapter 8: Study 4. Therapists' perceptions regarding both traditional and intensive CBT formats were investigated. Overall, intensive CBT was considered as fundamentally acceptable, but it was also clear that only a minority of therapists had experience in its delivery. The main perceived obstacle to the use of this format cited by therapists' were service-related restrictions at a practical level. Therapists also expressed concern regarding the evidence-base and potential for relapse.

In Chapter 9: Study 5, the findings of Studies 2, 3 and 4 were drawn on to inform the development of the Treatment Preference Questionnaire (TPQ). The TPQ was used to investigate OCD participants' preference for format of treatment. Participants who expressed an overall preference for intensive CBT had undertaken a greater number of previous courses of weekly CBT, were more functionally impaired or had previously experienced intensive CBT.

Chapter 10: Study 6 drew on the findings of Study 3 and 4 in which both patients and therapists expressed concern regarding the possibility of relapse following CBT. To consider problems that are known to occur clinically, but for which there is little empirical data, we examined the views of participants who had experienced a recurrence of symptoms after successful treatment. This study identified specific stressors, cognitive and behavioural patterns and issues related to a lack of follow-up as being linked to relapse.

Synthesis of Findings and Clinical Implications

Across the studies of this thesis two overarching themes were identified; 1) *Subtext* and 2) *Content* of therapy. The theme of *subtext* pertained to factors that are intangible that participants brought to therapy that were related to or came into being because of participants' previous experiences of unsuccessful CBT. The second key theme relates to the *content* of therapy and how key elements (perceived by both the service user and therapist as important) were delivered.

Clinical Implications for Case Formulation: Unpacking previous experiences of CBT

In relation to the overarching theme *subtext* the findings from Chapter 6: Study 2 provide insights into how therapists should, or rather should not, begin therapy from the perspective of patients. It is clear that how the therapy is initially set up can be integral to participants' engagement. Our data indicates that beginnings in therapy require careful consideration, particularly when working with patients for whom previous CBT has not fully helped. The findings of Study 2 and 3 taken together emphasise the importance that service users' place on being 'understood', understanding the rationale for treatment, and ensuring there is enough time in the therapy session for these factors to be facilitated. The first clinical implication that stems from these findings relates to case formulation. Case formulation has been established as the key method in CBT (Eells, 2011) for bridging the expertise inherent to both the patient and therapist. Findings from Study 2 indicate that case formulation was present in CBT for most participants in at least one previous episode of CBT. This indicated that its technical inclusion in therapy is *necessary* but *alone* is *not sufficient*. This illuminates that it is not just *what* is done in therapy but *how* it is done that is also important. Our findings suggest that the *subtext* that provides scaffolding and is a part of the process of developing the formulation (which aids in rapport building) requires careful consideration.

Specific to this, Kuyken et al. (2009) suggest that there should be levels of case formulation that develop over the course of therapy (i.e., early, mid, late, booster). These formulations serve different functions depending on the stage of therapy (e.g. socialisation to the model, rationale for ERP/ BE etc.). Thus, in line with these principles, the recommendation is that for patients presenting for their second or third course of CBT, the use of more than one initial formulation may be warranted. In addition, more time may need to be invested in the process of formulation than would usually be dedicated to this process. Specifically, our findings suggest that time should be invested in understanding the participant's previous therapy experiences and how these relate to their current therapy. Gaining specific information about what the patient perceived to 'work' or 'not work' in

their previous treatments, and the reasons for that, is likely to be particularly important. This information can help to illuminate the relevant *subtext* that needs to be considered by the therapist (i.e. beliefs that the patient is bringing with them, that may amongst other things influence the shape of their relationship with the current therapist). Case formulation can be used to facilitate this work.

Clinical Implications for Case Formulation: Unpacking meaning and impact on Therapeutic Alliance

The second clinical implication relates to the overarching theme of *subtext* and how this may impact the therapeutic relationship. In addition to discussions of experiences of previous treatment, the interpretations the patient has made about their previous unsuccessful CBT and the meaning that this has for them is likely to also be important. The psychological impact for patients identifying with the idea of experiencing 'treatment failure' or feeling like a 'treatment failure' or worse being labelled a 'treatment failure', or as 'treatment resistant', are likely to be detrimental, disempowering and potentially a part of what the patient brings with them to therapy.

The findings of Chapter 10: Study 6 found that participants had strong emotional reactions to relapse and the return of their OCD. Amongst these reactions were feelings of shame and desperation. In line with this finding, is research that has extensively examined the impact of stigma (public and self-stigma) and the barrier it can create to engagement with mental health treatment, specifically for those with OCD, as well as the its role in disengagement with therapy (Byrne, 2000; Corrigan, 2004; Rüsch et al., 2009). Specifically, stigma, shame and treatment perceptions have been identified as barriers to treatment engagement for patients with OCD (Chasson, Guy, Bates, & Corrigan, 2018; Marques et al., 2010). This research supports our finding and thus we suggest that without addressing relevant beliefs, this could impede therapy (regardless of how technically adequate the CBT may be) and impact on the therapeutic alliance. Labelling and stigma can of course also influence mental health professionals views on likely outcome and thus the care that a patient is provided (Harrison & Gill, 2010). Thus, this also serves as a reminder for therapists to reflect on and challenge such possible beliefs if present.

Returning to the focus on case formulation discussion of such beliefs may also be incorporated here. Although this is likely to extend the time generally allocated to initial formulation, our findings suggest that is may well be worth using. As shown in Study 2, without a foundation of collaborative understanding, the building of the other fundamentals (e.g. effective alliance, trust etc.) that are required for therapy, are unlikely to follow. In

particular, delivering therapy as if it is the 'first time' to people who have previously experienced treatment failures risks them disengaging, which can result in significant costs for the individual and service. These suggestions are supported by RCTs which have demonstrated that low therapeutic alliance within the context of CBT for OCD is associated with worse therapeutic outcomes (Keeley et al., 2011; Simpson et al., 2011; Vogel et al., 2006). A study investigating therapists' views on factors that undermine CBT for OCD also reported that a key factor identified by therapists' was therapeutic alliance not being strong enough (Jacobson et al., 2016). We suggest that time could be given to this at the beginning of treatment and case formulation could be used to facilitate such discussions. Alternatively, this could be flagged early in therapy and returned to when judged to be clinically appropriate. Our findings suggest that it would be important for the therapist to be cognisant of these factors when reflecting on progress in therapy.

In summary, the findings of the current research suggest avenues of inquiry that can be added to the formulation framework for this population (i.e. past experiences of therapy and patients meaning and interpretation of CBT that has failed to help them). The unpacking of these issues are likely to be important to the building of rapport and subsequent therapeutic alliance when working with individuals who have experienced multiple previous CBT failures.

Synthesis and convergence of findings between studies

There was convergence in the findings of the qualitative studies within this thesis. In particular, therapists' perspectives on intensive treatment (Study 4) were closely aligned to those of service users (Study 3). The views that were shared pertained to;

- Momentum and continuity
- Expectation of rapid change/ gains
- Longer sessions facilitating more in-session therapist assisted ERP
- Greater engagement in therapy
- Positive impact on outcome
- Concerns re: emotional impact on the patient/ therapist
- Practical barriers to access/ implementation
- Concern re: potential for relapse

As listed above participants widely endorsed the intensive approach however, key concerns were also raised. The qualitative findings did not transfer into a strong preference for intensive CBT on the Treatment Preference Questionnaire which examined OCD

sufferers' preference for format in Chapter 9: Study 5. The larger sample utilised in Study 5 was able to illuminate some of the characteristics of this group of participants who did not prefer intensive treatment. A preference for an intensive treatment was specific to those who had previously had multiple previous experiences of CBT, or had previously tried intensive CBT, as well as participants with increased levels of impairment. These findings indicate that an option of an intensive version of treatment or some longer treatment sessions would be most suited to these patients. This is also in line with the NICE (2005) current recommendation. Support for this finding is also provided by Jacobson and colleagues (2016) who reported that a large proportion of therapists (79% to 88%) reported that functional impairment, symptom severity, chronicity, and comorbidity were endorsed as factors thought to interfere with treatment, which was predominantly delivered on a weekly basis. Little research has looked at patient preference and the effect of this on outcome. However, the importance of considering patients preferences is highlighted in the depression literature. Meyer and colleagues (2002) found that the relationship between treatment expectancy and outcome is mediated by patients' contribution to the therapeutic alliance. This implies that for patients who expect their treatment to be effective they engage more consistently and constructively, and those who do not, are more likely to disengage from treatment. Thus, where possible, seeking patient preference for treatment and offering treatment that is aligned with this may also be useful for building rapport and alliance with participants with the experience of multiple treatment failures.

Longer Sessions Utilised for In-session ERP

One of the key shared themes across the studies was the perceived benefit of longer sessions. This falls under the overarching theme of *content.* The findings of Study 3 indicate that it is not exclusively an intensive version of CBT that service users expect to be useful. Rather hybrids of intensive longer sessions amongst weekly sessions were proposed by participants. Service users in studies 2 and 3 highlighted problems for which longer sessions (provided in an intensive or a hybrid format) could potentially provide solutions. The underuse of ERP from the service users' perspective was a strong theme throughout the studies of this thesis. Service users predominantly reported longer sessions could be used for in-session ERP, which was also consistently reported by therapists. This pervasive finding is in contrast to research that suggests that ERP is not acceptable or wanted by services users (Kozak, 1999). The clear message from this research was that service users wanted ERP but recognised that it is difficult and challenging to undertaken and thus understandably want support with this, at least initially, in the form of in-session therapy assisted ERP. Across the

studies participants reported difficulties with being assigned ERP for homework without previous in-session modelling or in-session attempts.

Similarly, in a study examining a large sample of therapists who reported on their treatment of OCD, therapists viewed ERP as a key aspect of treatment, although most therapists reported that ERP was administered as a part of out-of-session homework, with few therapists endorsing the use of in-session ERP (Jacobson et al., 2016). The same study also reported that therapists identified that patients not undertaking their homework between sessions impacted negatively on outcome. This handing of responsibility to the patient for a central component of therapy is highly problematic: the evidence from a meta-analysis of CBT for OCD indicates that in-sessions exposure predicted better outcomes than reliance on out-of-session exposure (Abramowitz, 1996). The findings of the current thesis show that the views of both therapists and patients are consistent with this observation.

The Underuse of In-Session ERP.

Overall, it seems likely that the problems with delivering ERP substantially lie with therapists, given the clear indication from patients that this is a deficit they identify in treatment. A range of reasons have been proposed as to why therapists fail to implement EPR such as; therapists' ambivalence about the patient's ability to tolerate ERP, fear of increasing distress or exacerbating symptoms (Deacon & Farrell, 2013; Meyer et al., 2014; Moritz et al., 2019) the therapists own anxiety, coupled with a lack of training or experience (Cahill, Foa, Hembree, Marshall, & Nacash, 2006; Gaston, 2015). The underuse of evidence-based techniques essential for activating change is a problem that extends beyond the treatment of OCD to other disorders (e.g. in PTSD reliving interventions can be enhanced by cognitively restructuring peritraumatic hotspots (Grey, Young, & Holmes, 2002). Such interventions are reported to be underutilised due to similar reasons as identified above) (van Minnen, Hendriks, & Olff, 2010). The obvious solution appears to be the use of education and additional training in these specific areas followed by supervision. With several studies demonstrating significant improvements resultant from brief therapist training and subsequent supervision (Grey, Salkovskis, Quigley, Clark, & Ehlers, 2008; Sholomskas et al., 2005). However, this does not seem to be the case for therapists treating OCD. For instance, the International OCD Foundation (IOCDF) developed a training institute with the specific aim of encouraging therapists to adopt and implement evidence-based interventions in their practice for OCD (Reese et al., 2016). Following this specialist training, ongoing supervision was associated with greater skills use. However, the largest reported barrier to integrating techniques was the restriction of the time in sessions and the therapists inability

to leave the office setting (Reese et al., 2016). This highlights a circular problem, that is; patients want in-session ERP/ BE, therapists recognise the benefits of this but despite specific skills training and supervision the implementation of in-session ERP/BE is still underutilised. The largest barrier to this being the time restrictions of the session and service-related restrictions.

Service-Related Barriers.

In Chapter 8: Study 4 therapists reported that they were substantially constrained by practical barriers, specifically a predetermined allocation of therapy sessions and the time restrictions of the 50-60 minute therapy session. These factors were reported as making it harder to implement *in vivo*, therapist assisted ERP. This is consistent with the findings detailed and above and also of Moritz et al. (2019) who found that therapists reported organisational difficulties as a barrier to implementing ERP. Moritz et al. (2019) also noted that when ERP is undertaken in a standard hourly session, the time span is likely to be too short as ERP protocols are generally based on the presumption of a 90-minute session (e.g. Foa & McLean, 2016). The consequence of this may be that essential elements, including sufficient preparation and unpacking of what was learnt, are omitted. This may relate to the perpetuation of the findings of Study 2, in which participants perceived a clear treatment rationale to be missing.

To enable therapists to implement the suggestions made above (i.e. additional time for inquiry, formulation, and in-session *in vivo* ERP) an element of flexibility is required. Time is required for the therapist to implement and also to reflect upon the intricacies of the case. Therapists in Study 4 identified that a key benefit of longer sessions would indeed be time to consider and pick up on the subtleties in their patient's presentation (reflecting, to some extent, the *subtext* identified by patients as described above), along with more time for practical elements of therapy (e.g., in-session ERP). The clinical implications identified here are relevant to services.

The findings from this thesis indicate that it is crucial that in order for ERP to be successful for this groups of service users, the use of in session ERP is important. This would then enable the transferability of learning to homework tasks. The findings also provide some insight into why individuals may not be compliant with homework and have implications for therapist's formulation of this when it occurs. This is a critical problem to address given the potency of ERP in affecting change in therapy.

Relapse, Follow-up and Aiming for Remission

The second shared key theme identified across the studies was the possibility of relapse and falls under the overarching theme of *content.* It is clear from the data that if an intensive format is adopted then follow-up is perceived to be essential. The findings of Study 2, 3 and 6[13] indicated that patients see great value in follow-up, yet it was reported to be rarely offered or received. The provision of some follow-up is considered a convention in clinical practice; however, it has received little research attention and it may be that, in the context of busy services, it is in fact overlooked. The findings of this thesis suggest that follow-up may help individuals to engage and commit to therapy knowing that there is follow-up available.

In Study 6 very few participants reported a complete recovery and a lack of follow up was a key factor identified as leading to relapse. Within the literature there is data available to indicate the gains participants have maintained after a specific passage of time. However, there is a dearth of literature on the importance of the actual follow-up sessions. However, it is clear from research that partial response is a predictor of relapse, with most relapse occurring in the first year post treatment (Braga et al., 2010). Further focus needs to be given to the issues of working towards remission in therapy and relapse prevention after the completion of therapy. This would then further inform NICE guidance on the provision of follow-up at different levels of stepped care. It is suggested that follow-up should be made available to service users much earlier in the care pathway as a part of routine care.

Findings from Study 6 indicated that a relapse prevention plan is considered to be of great importance to service users. As Kuyken and colleagues (2009) recommend the case formulation can be used at various stages throughout therapy and can be used to facilitate the relapse prevention plan. It is important that therapists ensure sufficient time is made available in session for this to be focused on. Further research exploring therapists' views on relapse prevention and the provision of follow up would be useful to illuminate possibilities from their perspective regarding the provision of both of these important elements.

[13] *Note:* Study 3 and Study 6 utilised the same sample of participants, thus the views of the same participants were sought on different issues within these studies.

Summary

In summary the findings of this thesis show that the evidence for the NICE guidance of an intensive version of treatment is built on weak foundations. However, there is evidence to suggest that intensive CBT may be well received by the group of service users for whom it is currently recommended within the NICE guidance. Offering such participants this format may have benefits for therapeutic engagement, rapport and potentially outcome. However, provision of this option will likely require overcoming service level and practical barriers.

Recommendations regarding fine-tuning of therapy provision, illuminate that it is not only what is done in therapy, but how it is done that is important. The specific subtexts that need to be paid attention to for patients who have had previous experiences of unsuccessful therapy were described. Implications for services and policy makers pertain to the flexibility in the provision of number of sessions and length of sessions. In addition, the recommendation of follow-up at earlier stages of the stepped-care model is recommended.

Limitations

The findings of the studies that comprise this thesis provide novel insights into treatment failure and the prospect of intensive CBT for people for whom standard CBT has failed. However, it is important that these findings are considered within the context of their limitations. The limitations pertaining to each study have been dealt with in their respective chapters thus the overarching limitations will be discussed here.

Sampling

The participants in the studies of this thesis were mainly recruited as samples of convenience, and thus cannot be said to be fully representative, which poses a potential threat to validity. However, the focus of this thesis was on unsuccessful treatment and seeking to understand factors relevant to this specific group of service users. All studies which focused on service users sought participants who had experienced $\geq$ 2 previous courses of unsuccessful CBT. Therefore, the samples recruited represented the most appropriate samples to draw from, to meet the aims of this thesis. Further to this, recruitment of fully representative clinical samples in both exploratory studies and RCTs for OCD is a common and a well-documented difficulty (Daunt, 2003; Robinson, Woerner, Pollack, & Lerner,

1996; Williams, Powers, Yun, & Foa, 2010). However, studies have examined the extent to which participants recruited to RCTs are representative of community outpatient samples, finding an 80% match of participants in a community outpatient sample with those included in at least 1 RCT (Stirman, DeRubeis, Crits-Christoph, & Brody, 2003). The largest reason for the absence of a match was the lack of RCTs on common but unrepresented diagnosis (i.e. adjustment disorder, dysthymia, mood and anxiety disorders 'not otherwise specified'). Thus although this is a limitation, we do not believe that this was likely to have had a significant impact on the study results. The sample sizes and response rates of the studies of this thesis were generally good and appropriate for the methodologies used.

The recruitment of therapists was through the provision of CPD workshops. The consequence of this recruitment strategy may be that participants are more representative of therapists who are enthusiastic about CBT and research. However, participants were recruited from workshops that were run in different parts of the UK (i.e. Exeter, Bath, Bristol, London, Newcastle and Oxford) meaning that therapists were from a range of different NHS Trusts. Nonetheless, recruitment via non-training-based avenues would provide further reassurance of the representativeness of findings.

Interview methods.

In Study 2 qualitative interviews were conducted in person face-to-face, which has traditionally been considered as the gold standard method for conducting qualitative interviews (Shuy, 2002). In an attempt to remove any barriers to recruitment the participant had the choice of travelling to the University of Bath for the interview or to have the researcher travel to them. However, one of the difficulties encountered with this study was the time it took to recruit a relatively small sample. It was hypothesised that the requirement of a face to face interview may have created a barrier, in a population that is generally hard to engage in research. Due to this experience, telephone interviews were utilised as the method of data collection in Study 3.

The use of telephone interviews can be viewed as a methodological strength of this thesis, as they have been found to elicit more honest responses due to the perception of anonymity and security that the telephone provides (Novick, 2008; Trier-Bieniek, 2012). Furthermore, it can be proposed that in today's world of technology participants may be accustomed to 'virtual' communication methods (Sweet, 2002; Tausig & Freeman, 1988). This may be particularly relevant to participants with OCD for whom the difficulties associated with OCD are often kept private and are hidden by sufferers (El-Sayegh, Bea, & Agelopoulos, 2003). OCD can be very disabling and consequently symptoms can make

traveling to appointments difficult, thus the use of the telephone is likely to increase the ease with which OCD sufferers are able to consider participating. The findings of Study 6 revealed that participants also experienced feeling of shame regarding their relapse, and thus the means of the telephone interview may have made the experience of this less shame provoking. The use of the telephone also increased the researcher's ability to reach geographically dispersed participants (Sturges & Hanrahan, 2004). The use of the telephone was advantageous with a larger sample (with more specific inclusion criteria) being recruited at a better pace via this method.

However, there are also limitations to this approach that should be noted. It is possible that the telephone may inhibit the interviewer's capacity to build rapport with the participant prior to the interview. The absence of visual cues, nonverbal feedback, and other contextual information are suggested to contribute to this, along with the risk that the participant may be distracted by other activities within their home environment (McCoyd & Kerson, 2006; Opdenakker, 2006). Guidance for conducting successful telephone interviews includes establishing contact in person prior to conducting the telephone interview if possible (Burke & Miller, 2001). In the research undertaken for this thesis, this did often occur as the researcher attended multiple service user conferences at which the researcher spoke widely to many potential participants. The researcher is also a Clinical Psychologist and the practice of building rapport is a key element of clinical work, thus the researcher had well developed skills in this area. No significant difficulties in rapport were experienced in the phone interviews.

The use of non-standardised scales

A non-standardised scale was utilised in Study 5, as no standardised scales had been developed to measure the variables of interest. The Preference Treatment Questionnaire was developed by experienced clinicians for the purposes of the research and was informed by the qualitative findings of the previously conducted studies of this thesis. The reliability tests carried out in Study 5 suggest that the scale has acceptable reliability. However, testing of validity was beyond the scope of what was possible within the realms of this thesis and therefore needs to be pursued.

Directions for Future Research

As described throughout this thesis and within this discussion chapter there are many areas requiring further research that stem from the findings of this thesis. Three key areas highlighted by the overarching findings of this thesis are proposed here.

1) Investigation of Hybrid Intensities of CBT

The studies of this thesis suggest that intensive therapy may not be a good solution for all individuals with OCD. While there are new developments with intensive formats offering promise, such as the Bergen 4-day treatment for OCD (Kvale et al., 2018), their efficacy is yet to be examined. In Study 3, some service users indicated that doing the groundwork in a weekly format was important and allowed time for trust to build. Following which the intensive sessions were particularly helpful. Thus, a direction for future research is to conduct a full audit of what current NHS services are providing in terms of CBT for OCD for service users who have multiple previous experiences of CBT. A larger and more representative evaluation of the current usage of intensive sessions or the capacity for expansion in this area, if appropriate, is needed.

In addition, it would also be useful to employ a similar study design to that used in Chapter 9: Study 5 to examine patients' preferences for a hybrid of weekly and longer sessions rather than purely an intensive format.

2) Research focused on Follow-up

NICE guidance clearly recommends that patients who receive intensive CBT should receive follow-up for a year once they are in remission, the occurrence of this in clinical practice is unknown and requires further investigation. The current thesis highlights the key importance of follow-up for all patients, but it was considered even more essential if an intensive format of CBT was to be used. As recommended above, a full audit of what services are currently providing in terms of follow-up and rates of relapse/ rereferral would provide useful baseline information. Research focused on developing relapse prevention interventions and how technology may be utilised to support this, is proposed as an avenue for future research.

3) Efficacy of Intensive CBT

As established in Study 1, there is insufficient research available to make specific recommendations for the use of intensive CBT for patients who have experienced multiple treatment failures. Therefore, of prime importance is a pilot randomised controlled trial comparing CBT delivered in a time-intensive format (or a hybrid) with standard weekly treatment and wait list. This is necessary to build on previous non-randomised comparisons and examine the efficacy, feasibility and acceptability of an intensive approach delivered in

an NHS outpatient setting. The participants should be patients who have previously not responded to ≥ 2 courses of CBT. This would also provide the platform for developing a full trial that is required to determine efficacy.

Conclusion

This thesis has shown that the understanding and treatment of OCD has progressed significantly, with major transformations over the past 50 years. However, despite the efficacy of standard CBT a significant proportion of participants do not respond and remain significantly impaired by their OCD. The prospect of intensive CBT as a possible treatment option was investigated. Intensive CBT or a hybrid of some longer sessions has the potential to provide the time to address fundamental aspects of therapy that may not be adequately catered for within a 50-60-minute session. The intensive session serves an important function, which may include one or more of the following; allowing time for idiosyncratic and collaborative development of formulation, building continuity and momentum, in-session therapist assisted exposure etc. Scope to provide some longer sessions as a part of standard CBT may provide possible options. This has implications for services in terms of provision and requires further research.

Despite the positive perceptions key barriers were noted on a practical and logistical level as well as concerns regarding the evidence base which are substantiated by the lack of well-controlled trials. In the large sample of OCD sufferers, the practical concerns were reflected. Intensive CBT was not the preferred treatment in general. Only a specific subset of participants who were more functionally impaired, had experienced multiple experiences of CBT or had previously experienced intensive CBT expressed a preference for CBT in an intensive format. A further key concern was the potential for relapse, particularly in the absence of follow-up. With the area of follow-up requiring significant research attention.

This thesis would suggest that further investigation into the efficacy and effectiveness of an intensive format or hybrid format of CBT be pursued. Future research in the form of an RCT is required to test the efficacy of intensive CBT for OCD for this group of patients. Further research on the provision of follow-up and the effect of such an intervention on the reduction of relapse is required.

In closing, the work of this thesis has enhanced the understanding of the factors relevant to treatment non response in participants who have experienced ≥ 2 previous courses of unsuccessful CBT. It has provided insight into the provision of intensive treatment for

this group, their perceptions and preferences. It has provided the first studies to examine the perspectives of both service users and therapists on an intensive format of CBT. It also provided the first study to examine service users' preferences for an intensive format of CBT. While it is not possible to determine the efficacy of an intensive version of treatment for this group of service users, qualitative reports regarding the acceptability of the approach are encouraging.

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APPENDIX A – REFLEXIVE OUTLINE

Reflexivity: What do we bring to the data and why does that matter?

What is reflexivity?
"Reflexivity begins with an understanding of the importance of one's own values and attitudes within the research process and this begins prior to entering the field. Reflexivity means taking a critical look inward - a reflection on one's own lived reality and experiences, a self-reflection or journey. How does your own biography impact the research process? What shapes the questions you chose to study and your approach to studying them? How does the specific social, economic, and political context in which you reside impact the research process at all levels?" (Hess-Biber, 2007, p. 129).

What do we bring?
It is essential to think about the various ways your 'position' in society impacts the way you observe and perceive others in your daily life. What particular 'values 'or 'biases', if any, do you bring to and/or impose on your research?

Why does it matter?
Thinking about what you bring to the data is important in all elements of the research process from conception through to analysis, reporting and discussing your data/ findings. What you bring can influence the design, materials you choose to use as well as developing the questions you will ask during your data collection. It will also shape what you notice in terms of different aspects with the data and what you may zoom in on during the interview process (e.g. similarities or differences in experiences/ risks of overlooking aspects of the data).

Please consider each of the following in relation to your research topic and makes notes for your personal reflection:

Socio-demographic positioning's (i.e. Marginality/ privilege, age, sex/ gender/ sexuality, race, class, ability etc.)

Personal background and life experiences (e.g. rural upbringing vs. the suburbs etc.)

Research training and research experiences

Political and ideological framework (overt and implicit)

Theoretical/epistemological/methodological assumptions

Personal experiences of, and assumptions about the topic you are researching